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Weighing up the bag of potatoes test: tribunals and Incapacity Benefit

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Although the original version of this dissertation was anonymised, some material from the original dissertation has been removed or amended to provide further anonymity for participants

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Chapter One
INTRODUCTION

In April 1995, a new social security benefit was introduced. It required the Benefits Agency to decide whether a claimant was capable of doing such things as lifting a 2.5kg bag of potatoes, putting on a hat, or walking sideways down stairs (ICB Regs 6(1)(b) Schedule, descriptors 8(d), 9(b), 2(e)). Incapacity Benefit replaced the old Invalidity and Sickness Benefits. It differed from Invalidity Benefit in several important ways. It was:

- paid at a lower rate than Invalidity Benefit;
- taxable;
- payable at its highest rate after 52 weeks, rather than 26; and
- assessed by a medical test (the `all work test') which looked at the claimant's ability to do certain functional tasks, rather than at an overall assessment of the claimant's ability to do a real job in the real world.

The change which is of most interest is the new method of assessment.[1] The new `all work test' for Incapacity Benefit introduced a set of apparently rigid rules which would define who was and who was not incapable of work.[2] The criteria (`descriptors') which attracted the most initial attention were the apparently absurd ones such as those involving bags of potatoes. The rest of the test might have been less open to satire, but critics were also concerned that people would be unfairly disqualified from benefit because of the rigidity of the test. Particular concern was expressed over those people `at the margins' who would be refused the benefit but who were clearly unable to work (Berthoud 1995). Chapter 3 discusses the all work test. Details of the test are in Appendix 1.

The Government made it clear that the purpose of introducing Incapacity Benefit was to cut the number of payments made. 220,000 people were expected to have their benefit stopped

[1] For full details of the other changes, see Bonner 1995.

[2] It was intended to identify when a person was incapable of doing *any* job - hence the name. This was not new - Invalidity Benefit had always been assessed on the basis of whether a person could do any job. Incapacity Benefit made it clear that the all work test should apply for most people after six months of being unable to do their normal job.

in the first two years. A further 55,000 new claimants (who would probably have qualified for the old Invalidity Benefit) were expected to be refused the new benefit by April 1997 (Hansard, 2 February 1995, col 1242).

The Government claimed that the abolition of Invalidity Benefit was necessary to curb the rising number of payments to people it considered to be fit for work. The rise in numbers of payments was not disputed, but Government explanations for this rise were questioned by a number of researchers. Chapter 2 discusses the policy background to the legislation.

The controversy surrounding Incapacity Benefit makes it a particularly interesting subject to study. The questions that were raised by the new benefit suggested that it would be useful to find out how the all work test was working in practice, after a year of operation, and what was happening to people who `failed' the test - mostly former recipients of Invalidity Benefit - and were found fit for work.

One way of addressing these questions was to look at the appeals made by people who were found fit for work under the new test. Those who are refused benefit have a right to appeal to a Social Security Appeal Tribunal. Given the Government prediction that large numbers of people would fail the test, 140,000 appeals were expected during the first year (Wikeley 1995, p532). Incapacity Benefit offered an opportunity for a case study on how Social Security Appeal Tribunals deal with a piece of new legislation, as well as offering a window on how the implementation was working in practice.

Aims and objectives

My purpose in this research was to look for evidence from appeal hearings on Incapacity Benefit which might shed light on three issues:

- procedures for assessing claimants under the all work test
- the operation of tribunals in assessing appeals under the all work test
- the suitability of the all work test in assessing incapacity for work.

Procedures

The assessment for Incapacity Benefit had three new and controversial features:

- the all work questionnaire
- the role of the claimant's GP
- the medical examination.

For full details of the assessment procedure, see Appendix 2.

The information gathered by these procedures was to be the basis for decisions by adjudication officers, and the primary source of evidence for tribunals.

If there were going to be problems in the implementation of Incapacity Benefit, then these were likely to be the key areas of difficulty. Although cases which reach Social Security Appeal Tribunals are not necessarily typical of all claims which are refused, the cases which came before the tribunals would give some indication of the success and failures of the assessment process.

Tribunals

Social Security Appeal Tribunals hearing Incapacity Benefit appeals were faced with a very different set of criteria from those used for Invalidity Benefit. They were expected to apply a more rigid test with considerably less room for discretion or the application of common sense (Bonner 1995). Procedurally the tribunals were different from other Social Security Appeal Tribunals because they included a medical assessor, whose role had not been clarified at the time of introduction of the new system (Bonner 1995, Wikeley 1995).

Research on other social security benefits has shown that an appellant's chance of winning his or her appeal is greatly enhanced if she or he has a skilled representative. An appellant who is not present at her or his hearing has even less chance of success (Genn and Genn 1989, Baldwin, Wikeley and Young 1992).

The experiences of appellants with and without representatives, and of those who were and were not present at their hearings would provide evidence about how tribunals were approaching Incapacity Benefit appeals.

The success rate of appeals would also tell us something about the effectiveness of the assessment procedures. It is often suggested that a high success rate implies that initial decision making is faulty. However, this is not necessarily the case and there may be other explanations (Sainsbury, Hirst and Lawton, 1995, p227).

The all work test

Finally, I hoped that the experience of tribunals would shed some light on the effectiveness of the all work test - the cornerstone of the new benefit - in its stated purpose of assessing incapacity for work.

Research questions

Using the evidence obtained from observing tribunals, and interviewing participants, I hoped to consider the following questions:

Procedures

Do cases which reach tribunal hearings highlight any particular problems with the questionnaire, the Benefits Agency Medical Service (BAMS) examination, or the role of the claimant's General Practitioner?

Do the problems suggest any changes in the procedure for assessment?

Tribunals

How do tribunals apply the new rules?

What happens to absent appellants?

What difference do representatives make?

What happens to unrepresented appellants?

What is the role of medical assessor?

What is the overall success rate of appeals?

If the success rate is high, is there an explanation?

The all work test

Does the evidence from the cases observed suggest that the all work test is an effective measure of incapacity for work?

How do the various participants in the process view the usefulness of the all work test?

The research project focused on a qualitative study of a small number of appeal hearings, followed by interviews with some of the participants in the process. Chapter 4 describes the method.

Chapter Two
POLICY BACKGROUND

The Government introduced Incapacity Benefit explicitly to cut social security expenditure by reducing the range of people eligible for the benefit, and the amount payable to each recipient. Expenditure on Invalidity Benefit had been increasing since the mid 1970s. The number of people receiving Invalidity Benefit had increased from 500,000 to 1,500,000 over the period 1975-92 (Berthoud 1995, p62).

History of Government policy

Indications of forthcoming cuts in Invalidity Benefit can be traced back to a National Audit Office report in 1989. This report sought to discover an explanation for the growth in expenditure on Invalidity Benefit over the period 1983-87, and to examine the control measures within the Department of Social Security to ensure that only those eligible for benefit were receiving it (National Audit Office 1989, p7). The National Audit Office concluded that 'a potentially effective control system has been established by the Department in a difficult and complex area' and that improved information and training would enable the Department to 'ensure that only claimants satisfying the qualifying conditions receive the benefit' (p5).

The Government discussed benefits for disabled people in its 1990 White Paper *The Way Ahead*. This proposed changes to the 'extra costs' allowances payable to disabled people both in and out of work, and a new means-tested benefit (Disability Working Allowance) for people in work who were considered 'partially able to work'. The Paper proposed reducing the value of Invalidity Benefit for individual claimants, but it did not consider the eligibility rules (DSS 1990).

In 1992 a series of government statements and leaked documents showed that Invalidity Benefit had been targeted as a means of restricting government expenditure (Wikeley 1995, p526). Around this time the DSS commissioned a series of research projects looking at the characteristics of Invalidity Benefit claimants and at GPs' involvement in the claiming process (Lonsdale, Lessof and Ferris 1993, Lonsdale 1993, Erens and Ghate 1993, Ritchie Ward and Duldig 1993).

Stricter controls in the assessment of Invalidity Benefit were introduced in the spring of 1993. However, even then, 80% of claimants referred to the Benefits Agency Medical Service were still found unfit for work, while of those who appealed against a refusal of the benefit, around 50% were successful (Howard 1994, p7).

The publication of the DSS research reports in the autumn of 1993 was accompanied by DSS press releases which indicated that the Government viewed the results as evidence in support of cutting Invalidity Benefit (Howard 1993).

The budget statement in November 1993 outlined the first detailed plans for the new Incapacity Benefit. It provided information about the new test of incapacity as well as the proposed taxation of the benefit and reduced payments (Reith 1993).

The consultation process

Shortly after the budget, the Government issued a consultation paper on the details of how the medical test would work, asking for comments by February 1994 (DSS 1993). At the same time, the proposed medical test was subjected to an internal review and development process (DSS 1994). 5000 copies of the consultation document were sent out, and 350 responses were received from a range of voluntary organisations, local authorities, professional organisations, and individuals (DSS 1994, p39).

Respondents criticised the short timescale for consultation and complained that the consultation process was taking place simultaneously with the development of the proposed medical test, giving the impression that comments would not be taken very seriously (Disability Alliance 1994). Responses also doubted the suitability of the new medical test as a means of measuring incapacity for work, as well as highlighting the particular difficulties which would be encountered by claimants with fluctuating disabilities, invisible disabilities, people who had side-effects from medication and people with mental health problems (Disability Alliance 1994, TUC 1994, DSS 1994).

In its response to the consultation process the DSS acknowledged that there had been many concerns about the medical test but chose to continue with the policy on the grounds that `the Government remains of the view that it is the medical condition which distinguishes the long term sick from the unemployed' (DSS 1994, p39). With the exception of some minor changes to the operation of the all work test, we might ask what the point of the consultation exercise was,

other than to lend legitimation to the whole process. It was not the first time that a consultation process had little effect on the result of a government social security policy (Adler 1988).

Why did claims for Invalidity Benefit increase?

The Government's view was that there were three causes of the increase in claims for Invalidity Benefit:

- an increase in claimants who were not genuinely incapable of work;
- an increase in GPs being prepared to sign sick notes for these people; and
- a change in the interpretation of benefits legislation by the legal system, widening the eligibility conditions (DSS 1993, p4).

There is a mismatch between the Government's assessment of the causes of the problem and findings from empirical research, including that commissioned by the DSS.

Increase in claimants not incapable of work

A number of researchers have also looked for explanations for the increase in claims. There appears to be a general consensus around the reasons for the increase in numbers of people claiming Invalidity Benefit (National Audit Office 1989, Erens and Ghate 1993, Lonsdale, Lessof and Ferris 1993, Berthoud 1995). These are:

- an increase in the number of people reaching pension age and continuing to claim Invalidity Benefit rather than Retirement Pension, for tax reasons;
- an increase in the number of women becoming eligible for Invalidity Benefit (because of the increase in women working generally and the decline of women paying the small national insurance stamp);
- a small increase in the number of people with long term illnesses. Although this might appear intuitively to be unlikely because of improved health care (the Prime Minister for example said that it 'beggars belief' that serious impairment could have risen (Berthoud 1995, p64)) there have been increases in people surviving with conditions which previously had been fatal, for example heart disease, but whose condition still limits their ability to work; and
- an otherwise unexplained growth in the numbers of people claiming.

This fourth point is the most controversial. However, even here there is agreement on certain issues. There is a general consensus that the increase was mainly due to people staying on benefit longer rather than to more people claiming (National Audit Office 1989, Disney and Webb 1991, Holmes, Lynch and Molho 1991, Erens and Ghate 1993, Lonsdale, Lessof and Ferris 1993). There is also a consensus that those staying on benefit longer are largely older men (Disney and Webb 1991, Erens and Ghate 1991, Holmes, Lynch and Molho 1991, Lonsdale, Lessof and Ferris 1993). Finally there is little doubt that there is a strong link between the rise in payments of Invalidity Benefit and the growth in unemployment through the 1970s and 80s (Disney and Webb 1991, Holmes Lynch and Mohlo 1991, Erens and Ghate 1993).

The conclusion seems to be that, amongst older men in particular, Invalidity Benefit has been used as a substitute for Unemployment Benefit, or as an early Retirement Pension for people who could not anticipate working again. In some senses this agrees with the Government's view - that people were claiming to be unable to work rather than unemployed. The problem arises when we try to distinguish between people who are unemployed because there are no jobs available and those who are unemployed because there are no jobs which they would be able to do or which an employer would employ them to do.

The Government view was that there was a clear cut 'medical' distinction between those who were capable of work and those who were not. However, many writers have found that it was extremely difficult to make this distinction. There were two reasons for this:

- the assessment of a person's 'medical' condition cannot be made objectively
- a person's medical condition interacts with social and environmental factors to determine how the person is able to function in everyday life.

Mashaw discusses the danger of assuming that an objective assessment can be made of a person's medical condition, bearing in mind that aspects such as pain tolerance, motivation and energy are not measurable in any objective way (Mashaw 1983, p63).

Disability cannot be defined wholly in terms of a person's physical or mental impairment. Barnes shows how a person's disability cannot be defined by their physical or mental condition alone but by the barriers created by society which limit what the person can do (Barnes 1991). A person's ability to work depends not only on impairment but also on a wide range of social factors which are difficult to define and which vary over time. Berthoud cites examples of how the age, sex, qualifications and work experience of the disabled person, the accessibility of

buildings and transport, and the attitudes of employers can make an enormous difference to whether an individual can realistically expect to be able to work (Berthoud 1995, pp70-77).

The Disability Alliance argues that any test of incapacity for work should look at what it is 'reasonable for the individual to do' because without this qualification 'no-one would ever be regarded as incapable of work, as most people are capable of doing something' (Disability Alliance 1994, p2).

There is considerable evidence to suggest that people with disabilities or health problems are discriminated against in the job market - and that this discrimination increases at times of high unemployment (Barnes 1991, p96, Berthoud, Lakey and Mackay 1993, p115, Berthoud 1995, p66, Hadjepateras and Howard 1994). Older people too are discriminated against by employers, a discrimination which has been actively promoted by governments, employers and trade unions, by promoting `early retirement' as an apparently painless means of cutting the workforce (Laczko and Phillipson 1991, p225). The combination of discrimination against older people and those with disabilities makes it unsurprising that there are high levels of unemployment amongst older men with disabilities or health problems (Barnes 1991, Berthoud, Lakey and Mackay 1993). Many writers have recognised that discrimination is a significant reason why many people claiming Invalidity Benefit felt they would not be able to get a job (Disney and Webb 1991, Holmes, Lynch and Molho 1991, Erens and Ghate 1993, Lonsdale, Lessof and Ferris 1993). According to Lonsdale et al, a person's 'chances of finding work may depend as much on employers' attitudes and on the availability of jobs adapted to their health problems as on these problems themselves' (1993, p6).

The implication is that the rise in Invalidity Benefit claims *was* affected by the growth in unemployment but not that this meant that people were making false claims about their capacity for work.

The role of GPs

The second explanation put forward by the Government was that GPs were failing to distinguish between those who were fit for work and those who were not. The role of GPs was looked at specifically in one of the DSS-commissioned research reports (Ritchie, Ward and Duldig 1993). This reported that GPs had concerns about their role in assessing claimants for Invalidity Benefit, and would have appreciated more help and training in this role, but that many also felt that it was

important that assessments were made by GPs since they knew their patients rather than other official doctors who would not have the full picture. Many GPs agreed that they considered wider social factors in assessing their patients' capacity for work, and were sympathetic to the problems of patients who were discriminated against in the job market, and to patients who would find the whole process of looking for work stressful and detrimental to their health (Ritchie, Ward and Duldig 1993). Many of these findings could have been anticipated from the research by the National Audit Office in 1989 which had endorsed the system of using GPs as assessors and recommended better training and support for GPs in the assessment process (National Audit Office 1989).

The DSS research findings showed that GPs had a difficult job which they were attempting to carry out fairly and sympathetically. It did not show that GPs were conspiring with their patients to defraud the system. In addition to this, the Government ignored the evidence that Invalidity Benefit claimants continued to be found unfit for work after internal DSS assessments and after appeals through the tribunal system (Lonsdale 1993, p14, Howard 1994, p7). If it was the case that GPs misunderstood the assessment procedure, claimants would have had their benefit disallowed at the review and appeal stage.

Legal interpretation

The third argument was that there had been a significant change in the interpretation of legislation by tribunals and social security commissioners. There is little evidence in support of this argument (Berthoud 1995, p65, Wikeley 1995, p527). The DSS argued that a key commissioner's decision 'broadened and blurred the definition of incapacity far beyond the original policy intention' by defining incapacity for work 'having regard to age, education, experience, state of health and other personal factors'(DSS 1993, para 3.1). The decision referred to was R(S)11/1951 - a decision made in 1951, three years after the implementation of the National Insurance Act which set up the sickness and invalidity benefits system, and which lasted as the key interpretation of the legislation for forty years. It is difficult to imagine how this could be described as 'broadening and blurring the definition beyond the original policy intention', let alone how it could explain the rise in claims in the last twenty years.

This series of events suggests a fairly smooth route from the identification of a 'problem' - the increasing expenditure on Invalidity Benefit - through research on the subject, to legislation.

However, it is clear that the Government's sole intention, from the start, was to cut expenditure, and that the research and consultation program had little effect on its eventual policy proposals other than to attempt to justify them (Berthoud 1995, Murray 1994, Wikeley 1995).

The evidence suggests that the Government's view of a clear cut distinction between capacity and incapacity for work is an over-simplification of the real picture: a picture which the Government's own research has shown to be much more complicated.

Chapter Three
THE ALL WORK TEST

Regulations

The all work test assesses a claimant's ability in each of 14 physical areas - ranging from walking ability to continence - and in four areas of mental disability (see Appendix 1 for details). The test defines `incapacity for work' as being a score of 15 points or more on the physical descriptors, or 10 points or more on the mental descriptors, or a total of 15 points on a combination of mental and physical descriptors (ICB Reg 25).

The Government was insistent that any new test for Incapacity Benefit should reflect incapacity for work and not disability but it is not all clear that this is what the new test does. The all work test was developed from measurements of disability devised for the Office of Population, Censuses and Surveys for its survey of disabled people in Britain (Martin, Meltzer and Elliot 1988). Comments on the all work test consultation document emphasised a concern about how the test had been devised, and the unsuitability of using the OPCS scales as a model (Disability Alliance 1994). The OPCS report explained that these measures would not be appropriate for `the assessment of individuals' because they were designed to find out how many people in the country had a disability (Martin, Meltzer and Elliot 1988, p59).

Exemptions

People who have certain types of severe disability are exempted from the all work test and are `treated as incapable of work' (see Appendix 1) - even though some of them would be perfectly able to work.

The DSS itself admitted that these categories of people are exempted from the all work test, not because they cannot work, but because `it would be unreasonable to expect the person to be, or to become, capable of work' (DSS 1994 p16). Similarly the all work test itself does not measure incapacity for work but the upper limit of the test is `the point at which a person *should not be expected to work* for benefit purpose' (DSS 1994, p35, my emphasis). This view was emphasised by the Minister for Social Security in the Commons debate on the new rules: `We all

know of people who are blind or use a wheelchair but who are perfectly capable of, and do, full-time work. We do not think those people *should be required to register for work* if they need to claim social security benefits' (Hansard, 2 February 1996, col 1239, my emphasis).

These people might appear to gain from a system which makes it easier for them to claim benefits but they also lose because the system reinforces the discriminatory attitudes which exclude disabled people from society - `Incapacity Benefit will send the wrong message to prospective employers and others responsible for important decisions about disabled people's lives' (TUC 1994, p8).

Guidance

One of the early criticisms of the all work test was that it was too rigid, and that there would be some people who, while clearly incapable of work, could not fit into the particular system that the all work test measures. There was also criticism that the all work test did not cater for people whose disabilities varied from day to day, and that a single test of physical function did not measure the difficulties experienced by people who had considerable pain or fatigue (Disability Alliance 1994, DSS 1994).

It was argued that these problems would be avoided because `BAMS [Benefits Agency Medical Service] doctors will be fully aware that their opinions should not just be based on the condition of the person on the day of the examination' (DSS 1994, p41). Pain and fatigue would be accounted for by ensuring that the test `is designed to relate to the requirements of work, by testing whether people can perform the activities effectively in the workplace and in the context of a normal working week' (DSS 1994, p42).

These reassurances did not find legislative form in the regulations dealing with the all work test (ICB Regs 1995). The regulations specify that the claimant `can' or `cannot' complete a task. There is nothing in the regulations to say how they should be interpreted. However, Benefits Agency guidance repeats the qualifications in the DSS statement that the test should not be a `snapshot' and that it should measure whether a claimant can complete a task `regularly and repeatedly' (Benefits Agency 1995a). This guidance has no legal standing and neither BAMS doctors, adjudication officers, nor tribunals are required to follow it.

Regulation 27

Another concern was that there would be people who would not fit into the rigid structure of the all work test, while clearly being unable to work. During the development stage of the all work test, the DSS ran a pilot scheme where existing Invalidity Benefit claimants were measured against both a doctor's independent assessment of their capacity for work and the new all work test. 23% of those whom doctors considered were incapable of work `failed' the all work test and would not have been eligible for Incapacity Benefit (Berthoud 1995). To protect this group of claimants, regulations were introduced which allow a claimant to be `treated as incapable of work'. These regulations cover people who:

a) have a previously undiagnosed potentially life-threatening condition; or

b) have a disability which would cause a substantial risk to mental or physical health if they were to be found capable of work; or

c) have a severe uncontrolled or uncontrollable disease; or

d) are due to have a major operation within three months (ICB Reg 27).

Regulation 27 (particularly clauses b and c) is in a sense the `let out' clause in the legislation. However, there are several problems with Regulation 27. Firstly, Berthoud argues that the pilot of the all work test was based on too small a sample (537) to find all the people who would have problems with the test, while the consideration of the Regulation 27 categories was based on a sample of only 22 people. It is possible that some categories of people will not be covered by either the all work test or Regulation 27 (Berthoud 1995).

Secondly, a claimant can only be excused by this regulation if a BAMS doctor is satisfied that the claimant meets one of the criteria. This means that there is effectively no appeal against the decision. The most that a claimant can do if she or he wants to be considered under this regulation is to ask a tribunal to adjourn in order for the question to be reconsidered.

Although the all work test appears to be rigid, there is clearly room for differing interpretations of it. Appeals from Social Security Appeal Tribunals to the Social Security Commissioners will create case law which will help to define what the all work test means.

Chapter Four

RESEARCH METHOD

Observation of Tribunals

Twenty appeal hearings were observed over five days during February, May, June and July 1996.

Access

Social Security Appeal Tribunals are open to the public, subject to the permission of the appellants and all those present at the hearing (Adj Regs 1995, Reg 4 (6) (d)). This meant that access should not have been a major problem but I needed to know when the hearings would be, and I wanted if possible to have access to papers in advance.

My plan was to negotiate access through the Independent Tribunal Service. When this approach was unsuccessful I approached local advice agencies who agreed to let me know the dates of hearings for which they would be providing representatives. The local office of the Independent Tribunal Service also gave me details of hearing dates.

Permission to observe

Permission to observe their hearings was gained by asking appellants in the waiting room before their appeal was heard. Most appellants were quite happy for me to observe. Only two refused permission. If the appellant was not present, my access to the hearing was dependent on the attitude of the chairman. Two chairmen invited me to observe unattended hearings, which enabled me to observe three of these.

Papers

The major disadvantage of being refused assistance by the Independent Tribunal Service was that I was unable to get papers in advance of hearings, and did not get copies of written decisions. In some cases I was able to have a look at papers and decisions afterwards.

Selection

The small scale of the study meant that the sample could not be representative. It was limited geographically to tribunals in a local area. The selection of individual cases for observation was made on the basis of those appeals listed on the days I was available to attend. There was no attempt to select particular types of hearings, or those involving claimants with particular characteristics. Details of appellant characteristics and tribunal characteristics are given in Appendices 3 and 4.

Recording of observations

All hearings were recorded by taking verbatim notes (or as close to verbatim as possible). Factual details of each case were recorded in a standard form. It would not have been acceptable to use a tape recorder during hearings.

Interviews

Nine interviews were conducted during August and September 1996: interviews were conducted with two appellants, two presenting officers, two representatives and three chairmen. As with the tribunal hearings, the numbers were too small to make random selections of interviewees.

Instead I selected interviewees from the hearings I had observed, using practical considerations and attempting to gain a range of views.

Appellants

Two appellants were interviewed: one who had been represented and had won the appeal, and one who had not been represented and had lost. Contact addresses were obtained from the appellants in the waiting room at the tribunal.

Presenting Officers

Presenting officers were contacted through local Benefits Agency offices. Both of those approached initially were happy to be interviewed.

Representatives

I had met the representatives at the hearings and obtained contact details from them there. I interviewed two representatives from different organisations.

Chairmen

I had observed five different chairmen. Chairmen were contacted via the Independent Tribunal Service. One was not willing to be interviewed. The other three whom I contacted were willing to give interviews.

Style of interview

Interviews were based on a semi-structured questionnaire - see Appendix 5 for details. Some interviews were tape recorded, in others answers were noted on the questionnaire. Interviews took place in appellants' homes and at the offices of presenting officers, representatives and chairmen. Each interview lasted between 45 minutes and an hour.

Analysis

A breakdown of tribunals is included at Appendix 4, giving details of the age, sex and disability of appellants, whether they were represented or not, whether they were present or not, the length

of the hearing and the adjournment, the number of points awarded before and after the hearing, and the result of the appeal.

The profile of appellants whose tribunals were observed was comparable to the profile of claimants of Invalidity Benefit under 60[3] (source of Invalidity Benefit figures: Lonsdale, Lessof and Ferris 1993).

Personal details of interviewees were collected but are not included here, in order to preserve the anonymity of those interviewed. Interviewees are not linked to specific hearings for the same reason.

Verbatim transcripts of tribunal hearings, and notes of interviews, have been analysed according to the questions set out in the introduction. Further material was collected on the more general issue of tribunal procedure but is not included here, as the main focus is on Incapacity Benefit.

[3] The transitional regulations protected the benefit of claimants who were over 58 at the time of the changeover to Incapacity Benefit (Transitional Regulations, 31). This meant that there were no tribunals regarding the all work test for people over 60.

Chapter Five
RESEARCH FINDINGS

Procedures for assessing claimants under the all work test

The questionnaire

One of the innovations of Incapacity Benefit was to introduce a 20 page 'self-assessment' questionnaire as the initial stage in the assessment process (Benefits Agency 1995b). Self-assessment had already been tried with other disability benefits - Disability Living Allowance/Attendance Allowance and Disability Working Allowance. Disability groups had been generally supportive of the idea of self-assessment, but there were also reservations about the suitability of the questionnaire when it focused so closely on the medical test (Disability Alliance 1994, DSS 1994). A concern about the use of the questionnaire was that people would have problems filling it in. Research on similar questionnaires shows that, although most people do not have difficulties describing their disabilities, a significant minority have serious problems (Silke 1993, Hadjepateras and Howard 1992, Lindow and Taylor 1995, Sainsbury, Hirst and Lawton 1995, Hedges and Thomas 1994, Corden 1995). The hearings observed and the interviews showed that there were a range of problems. One was the difficulty of describing a person's disability:

> REPRESENTATIVE: Standing - Mr M can't stand for more than 10 minutes. He agrees that he ticked the wrong box on the questionnaire for this - he should have ticked the box that said that he can stand but has to move around after 10 minutes. [hearing 1]

> Some people have trouble deciding whether they fit into a certain box or not - they have something wrong with them but they can't make up their mind which box they should be ticking. [interview, presenting officer 1]

Another problem area was when the claimant's disability did not seem to fit the questionnaire:

> WING MEMBER: When completing the form you didn't tick any of the descriptors. Why not?
> WITNESS: The main problem is the dizziness. The form doesn't have any questions about that. When we filled the form in he was very optimistic. He doesn't like to admit that he is unwell. His sight for example - the form asks 'Can you read? Can you recognise a friend across the road?' He can do those things. But it doesn't ask if after a few minutes do the letters dance across the page. The questions didn't ask the right things. It was almost like we were filling in the wrong form. [hearing 17]

> It was difficult to describe how my energy levels affect what I can do. I didn't mention the difficulties I sometimes have with going to the toilet or how bad nights affect what I can do the next day. There were no questions about this. It was too narrow - focused on particular questions. If it wasn't written down you wouldn't get it. [interview, appellant 1]

In answer to concerns about the rigidity of the form, the Government had emphasised that people would have an opportunity to explain their difficulties in more detail, and in particular to describe the effects of pain, fatigue or stress (DSS 1994, p40). Some interviewees emphasised the fact that people do not use the form to describe their difficulties in detail:

> It's sometimes difficult for them to give an objective answer. Some people use the space at the end for `any other problems' but most of them don't. [interview, presenting officer 2]

> People don't put enough information - it should be stressed that they should fill in as much as possible. People tick `yes' to a difficulty but they don't elaborate to say what the problem is - and invariably they don't get scored on it. [interview, representative 2]

A particular criticism of the form was its inadequacy for assessing people with mental health problems:

> People with mental health problems are scuppered right from the start because there are no questions until they get to the very end of the form - the box that says `is there anything else that you haven't told us about' ... It's very unusual for anyone to fill in that part of the form. [interview, representative 1]

> Where I find they are not using the boxes is the last big box where it asks if they've got anything else to add, particularly mental health problems.... I think it should give greater prominence to the fact it would be terribly helpful, if you have mental health problems - try to tell us here about what your life is really like, who else could tell us about it etc. [interview, chairman 3]

This evidence confirms what has been found in previous research: that the forms pose considerable difficulties for some people. As some interviewees emphasised, the questionnaire is the basis of the claim, and it determines how the BAMS doctor approaches the medical test. If something is missed out on the form, the BAMS doctor will not assess that problem. The consequence is that the claimant receives no points for that area of difficulty and may be refused the benefit.

The BAMS examination

The Benefits Agency Medical Service (BAMS) examination is the main source of evidence for most claims for Incapacity Benefit.

Research on medical assessments for other benefits found a number of problems with them. These included: focusing too much on medical conditions and not enough on the effects of the condition (NACAB 1990); the difficulty of assessing variable conditions (NACAB 1990, Hadjipateras and Howard 1994); people underestimating their difficulties when describing them to an unfamiliar doctor (NACAB 1990, Hedges and Thomas 1994, Dick 1994).

Appeal hearings often focused on inadequacies or inaccuracies of the examination. These criticisms fell into the following categories:

Statements from BAMS doctors which were based on a misunderstanding of the appellant's statement:

> REPRESENTATIVE: Stairs - Mrs M notes that she can walk up and down stairs - but she has to hold on and take a rest.... The doctor awarded no points.... The doctor's judgement is based on his evidence of her getting up from the couch and the fact that she came by bus. [hearing 20]

> I tried to describe to her how I get so very tired - I told her that I'd been at a party and I got up for a couple of slow dances and then the next day I was exhausted. She [the doctor] just wrote down `can't dance' - that wasn't what I meant. I was upset. I was angry at what the BAMS doctor had written about me. She said that I wasn't making an effort. I was in pain and I was tired and she was writing as if there was nothing wrong with me. She made me sound as if I was really healthy. [interview, appellant 1]

> The doctor asked questions about hobbies and misunderstood what I said. I told him that I had to pack in playing golf but that sometimes I go and watch the youngsters playing football out the back. He wrote down that I could stand because I watched the football. I think that went against me. [interview, appellant 2]

In some cases the appellant disputed factual information from the BAMS doctor - such as how she or he had travelled to the medical:

> REPRESENTATIVE: The BAMS doctor said that you ... came in to the medical examination by bus. Buses are very uncomfortable - do you travel by bus?
> APPELLANT: No.
> REPRESENTATIVE: Did you that day?
> APPELLANT: No - I got a lift. [hearing 4]

Some interviewees were concerned about BAMS doctors making assumptions based on claimants' statements about their daily activities:

> I've been quite horrified at some of the reports we've seen. There's a lot of jumping to conclusions - a lot of trick questions which I suppose you have to expect - someone said she could listen to a concert - this gets taken as `she can sit comfortably through a two-hour concert', having said that she can't sit comfortably for more than x minutes.... People are often quite concerned about what is said. Some say `that cannot have been me' - they actually thought that what is down is so entirely different from what they remember that they've seriously thought that it's been somebody else's notes. [interview, representative 1]

> You get comments like `I went on holiday' - the BAMS doctors say his back can't be that bad. You go to the tribunal and the man says `but I had to lie down for a week'. You get `he goes shopping' and you go to the tribunal and he says `oh yes but my wife pushes the trolley - she unloads the bags and everything'. They should concentrate more on the medical side of things - the type of strong medical evidence you can get is that someone with a back condition can touch his toes etc. [interview, presenting officer 1]

The other presenting officer, on the other hand, felt that subjective evidence was essential:

> He observes what the customer does and makes an impression. The doctor will ask things in a roundabout way about lifestyle etc when the customer is at ease. Sometimes the clinical facts tie in with what the customer has said, sometimes they don't. That is helpful information. [interview, presenting officer 2]

There was evidence that some BAMS doctors were not following the guidance which requires them to consider whether a person can do a task repeatedly:

> CHAIR: Mr M, do you have anything else to say?
> APPELLANT: Just at the medical - [the doctor] asked me to pick up a blood pressure machine - I lifted it up and put it down again. If I'd held it for any length of time I would have had a problem. [hearing 7]

> PRESENTING OFFICER: He [the doctor] doesn't seem to have listened to what Mrs S has said. This is what the BAMS doctor should consider: `Assessments must not be a snapshot - they must represent whether the function can be done regularly and repeatedly enough to allow regular attendance for work and in a fit state to do the reasonable duties of the job'. [hearing 3]

> Someone might be able to do something once but it doesn't mean they can do it in such a way as to hold down a job. You have to look at it slightly differently. That's the correct interpretation of the test. [interview, chairman 1]

Similarly there were times when the BAMS doctor had not taken account of the variability of conditions:

> CHAIR: [to medical assessor] Can you say anything about the discrepancy between the BAMS doctor and the evidence from the GP?
> MEDICAL ASSESSOR: On the day of the examination the client performed well - that may have been because they were short tasks. The doctor mentioned worsening memory and ability to concentrate - this was not assessed in February. These can contribute to variability in performance. [hearing 17]

> APPELLANT: The doctor doesn't know me. He only saw me for a few minutes. He hasn't seen me over a period of time.
> CHAIR: That's a perfectly reasonable comment. You are not alone in this. We have noted your comment. We are aware of the general background of the medical examination but I cannot see how else it could be done. [hearing 1]

Concerns that people would not tell the doctor everything were also borne out by evidence from some hearings:

> CHAIR: How long have you had hypos - were you having them at the time of the medical assessment?
> APPELLANT: Yes - but I didn't realise it was relevant. [hearing 8]
>
> PRESENTING OFFICER: The clinical history has no mention of alcohol.
> REPRESENTATIVE: Mr P only told me about it on Monday. He hasn't had a drink since March - since his wife took early retirement.... Perhaps it's not the sort of thing you talk about.
> APPELLANT: I try to hide it. [hearing 9]
>
> REPRESENTATIVE: She found it difficult to answer the questions, she couldn't think of what to say. She didn't elaborate for the doctor. [hearing 12]

One possible remedy for the deficiencies of BAMS examinations would be to allow more time for each examination. Doctors working for the Benefits Agency complained about the short time allowed for each examination, and the amount of information they were expected to collect in this time (*Guardian*, 29 October 1995). This view of the BAMS examinations as being very short was confirmed by some interviewees:

> The worst thing may be that it's only a 30 minute examination - that doesn't compare with a GP's word who has maybe known you all your life. [interview, representative 2]
>
> I think my view of the BAMS doctors has changed - I used to treat them as the holy grail but one or two cases have made me look differently. I came to the view that they were being overly strict. It's a very short interview - 30 minutes - heavily based on symptoms - they don't ask the questions that you want to have asked. [interview, chairman 1]
>
> Some of them are definitely showing signs of pressure to get through a lot of them and are not as complete. Others are very very good. [interview chairman 3]
>
> They say `I was only in there 15 minutes and they didn't ask me any questions' sort of thing - one does suspect that there is a grain of truth in that, from the point of view that the BAMS doctors are under a lot of pressure to get through a large number of cases in a short time - but most of them are fairly professional in the way they go about it.... It's the old story - they could take longer - but that would cost more money so in practical terms they wouldn't do it. [interview, chairman 2]

The evidence suggests that, at least in some cases, the BAMS examinations are failing to uncover the full extent of people's disabilities. The adjudication officers are giving particular weight to the BAMS report which means that people are refused the benefit.

The role of the GP

One of the major changes introduced with Incapacity Benefit was the removal of the GP as a `gatekeeper' to the benefit. The GP's role was reduced to that of providing an initial medical certificate (the Med 4) which gives a diagnosis and a description of the main disabling effects of the claimant's condition. The GP does not give an opinion on the claimant's capacity for work (DSS 1994, p12). As well as the initial Med 4 certificate, the adjudication officer or BAMS doctor can request further medical information from the GP at various stages.

The research showed that sometimes there was inadequate evidence from the GP:

> REPRESENTATIVE: The GP says the physical signs are `as one might expect'. Perhaps the Medical Assessor could help us with this? [hearing 2]
>
> PRESENTING OFFICER: His GP says he is awaiting a surgical assessment but there is no information on the effects of his disability. [hearing 6]
>
> CHAIR: I'm not sure the [BAMS] doctor gave sufficient weight to the evidence. It was not as well explained as [the representative] has explained it. The GP didn't say anything either. [hearing 8]

Interviewees were particularly concerned about the inadequacy of the information on the Med 4 certificate:

> They should make better use of the Med 4s. A lot of GPs are not returning them or they are not completing them very fully. They should be encouraged to complete the Med 4s more fully. That might increase the number of cases that were allowed - the GP's opinion carries a lot of weight - but it would cut down on the number of BAMS examinations we have to do and it would cut down on appeals. [interview, presenting officer 2]
>
> The Med 4s are absolutely useless - they just say `back pain, signed off until further notice'.... I don't think GPs are aware of the requirements of the medical test - because of what they put on the Med 4s ... I don't think GPs realise how strict the BAMS test is. [interview, chairman 1]

Another concern was that, when the GP did give information, it was not given sufficient weight:

> They seem to ignore what the GP and the hospital say. The hospital is doing all these investigations - they wouldn't be doing that if they thought it was a waste of time - if they didn't think there was anything wrong with me. [interview, appellant 1]

> The GP could be present at the medical test - then the doctors could discuss your case together. As it is the test is undermining the authority of the GP - you might as well light the fire with the doctor's line. [interview, appellant 2]

It seems that, in the attempt to reduce the role of the GP, an important source of evidence about the claim is being lost or given too little emphasis. Some interviewees suggested a compromise:

> I would like to see more information from the person's own GP - more weight being given to that. A GP does end up knowing their patient.... Maybe they could use something along the lines of the medical questionnaire that's sent for DLA - where they ask directed questions about aspects of a claim form that they need more information about. [interview, representative 1]

> The trouble is that the whole point of the system was to get the GP out as a keyholder to benefit - I think it would be difficult to go back to that. Perhaps if we got a brief factual report from the GP of the kind you get for a DLA case - that would be helpful. [interview, chairman 2]

The use of the GP probably varies considerably from one adjudication officer to another. More use could be made of the GP to clarify points where the BAMS doctor disagrees with the claimant's assessment of the problem.

The operation of tribunals in assessing appeals under the all work test

It has been well established that the chance of an appellant winning their appeal is influenced by whether or not they are present at the hearing, and whether or not they have a representative (Genn and Genn 1989, Baldwin, Wikeley and Young 1992). This was so for Invalidity Benefit where 19% of unattended appeals were upheld, compared with 57% of appeals where the appellant was present without a representative, and 73% where the appellant had a representative (DSS 1995).

National figures for the success rate of Incapacity Benefit appeals, broken down in this way, were not available at the time of writing. However, the evidence from this research indicates that the pattern is likely to continue with Incapacity Benefit (see Appendix 4).

The fate of appellants who do not attend their tribunals, and of those who are represented can give us a clue about the effectiveness of the procedures for deciding their claims.

Absent appellants

Interviews with presenting officers and chairmen confirmed the view that it was unlikely that an appellant who was not present could win her or his appeal.

> It makes a big difference. They're not there to give any evidence. So all the tribunal has to go on is what's happened so far - so they don't get it. [interview, presenting officer 1]

> It's not that we could never uphold an appeal if the person isn't there, and it happens with other benefits; but with Incapacity Benefit so much is based on the evidence - the information from the claimant. [interview, chairman 3]

> Normally that would mean the decision would be upheld - because you've got nothing to go on but the BAMS documentation - the adjudication officer's decision is based on that. Unless you have something in the papers that is way out of order it is likely you would uphold the decision. [interview, chairman 2].

One presenting officer suggested that people do not attend their hearings because `they don't have a good case' [interview, presenting officer 2]. However, research has shown that the reasons are more complex, and are more likely to be a reflection of the appellant's confidence in the system than their confidence in their own case (Martinez 1988, Genn 1994). One chairman confirmed this view:

> I think there is a prejudice against the tribunals by claimants. They don't like tribunals and they don't believe we are independent. It's very sad. Sometimes people with good cases don't turn up for some reason that we never know. And it might just be because they don't believe in the system or because they are nervous of formal situations. [interview, chairman 1]

Sainsbury argues that the presence of the appellant is necessary to enable the tribunal to carry out its inquisitorial role. The appellant can `provide additional, or clarify existing, evidence' while the tribunal members can `check information and elicit evidence which may not have seemed

important or relevant to the appellant' (Sainsbury 1994, p301). Evidence from unattended hearings gives an indication of how tribunals approach such hearings and the difficulties they have in exploring the issues.

In one hearing there was no discussion of the possible merits of the appellant's case. The hearing lasted five minutes and consisted of the presenting officer explaining that the appellant had failed to attend a succession of medical examinations. The appellant had given reasons for each non-attendance which the presenting officer dismissed as excuses and which the tribunal members did not investigate further. Following this presentation the chairman asked the tribunal members if there were any questions - there were none - and brought the hearing to a close [hearing 11].

In the other two cases, there was more attempt by the tribunal to explore the issues but there was little hope of the appellant winning the appeal because the tribunal could not ask the appellant any questions directly.

In one case the appellant had described her difficulties with bathing her baby as an example of her problems with lifting and carrying:

> WING MEMBER: The doctor says she can't bath the baby because of the restriction on her neck.
> MEDICAL ASSESSOR: Presumably she can't lean forward to get the baby in and out of the bath. She seems to be able to lift the baby in and out of a cot. [hearing 18]

The tribunal mused on the possible answers to these questions but could not answer them. Had the appellant been there she might have been able to explain why she could lift the baby on some occasions and not others.

In the third case there was little evidence to support the appellant's case and again the tribunal resorted to hypothesising:

> WING MEMBER: Why would he want to exaggerate? The medical assessment suggests he was exaggerating.
> MEDICAL ASSESSOR: That would depend on his personality. It is difficult to assess without the person being there. [hearing 19]

The tribunal clearly tried to address the points made in the appellant's letter of appeal but could not do very much with the information. Again, after a short discussion (the hearing lasted 13

minutes) the chairman brought the hearing to a close, with little chance of the appellant having his appeal upheld.

Baldwin, Wikeley and Young argue that the reason for a low success rate of appellants who are not present is that, without the oral evidence of the appellant, the tribunal is more or less bound to uphold the arguments put forward by the presenting officer. They argue that hearings are greatly influenced by the written submissions of the Department of Social Security which 'set the agenda' for the hearings (Baldwin, Wikely and Young 1992, p103). A chairman confirmed that the tribunal would normally accept the submission:

> It does them no good. The submissions are written in such a way that there is a prima facie case that it should be upheld. Unless the claimant is there with their own evidence, in 99 per cent of cases they are going to lose it. [interview, chairman 1]

This is a problem when we consider the high level of unsatisfactory written submissions found by the Chief Adjudication Officer (Baldwin, Wikeley and Young 1992, p104). The 1995/96 Chief Adjudication Officer's report does not break down comments by each individual benefit; however, in the group of appeals which included Incapacity Benefit, concern was raised regarding 34% of submissions for appeals (these included Severe Disablement Allowance and Maternity Benefit appeals as well as Incapacity Benefit). The Chief Adjudication Officer's main concern with appeal submissions was the `supporting of an incorrect original decision' by the Benefits Agency (Chief Adjudication Officer 1996, p29).

This suggests that tribunals should not accept the presenting officer's decision uncritically. One option open to the tribunal in these circumstances is to adjourn the hearing to enable the appellant to appear. In one hearing the chairman suggested that he would have adjourned had the appellant not been there [hearing 3].

However, interview evidence suggests that pressure from the Independent Tribunal Service was causing chairmen to cut down on the number of adjourned appeals:

> Initially they were tending to postpone them and say they should be given the chance to present their evidence but there's a lot of pressure on them now - because that was leading to a big backlog of cases waiting to be heard. The pressure now is to go ahead. [interview, presenting officer 1]

Representatives

Writers have argued that appellants believe that all they have to do is tell their story and do not realise that, in order to win their case, they must prove that their circumstances fit within stringent regulations. Only an experienced representative who understands the rules can show how their case meets the regulations. Genn describes the role of the representative as one of `case construction' (Genn 1993, p404). Rutledge, in his advice to representatives, argues that a key role for the representative is to `bring the client's case within the entitlement zone laid down in the rules' (Rutledge 1996, p19). There was evidence in the appeals of representatives doing this. In particular, representatives often focused on the possibility of interpreting the all work test rules more widely, to include the interpretation given by the Benefits Agency guidelines.
The representative might focus on whether the person could sustain an activity:

> REPRESENTATIVE: The basic problem is not so much reaching and lifting but how long he can sustain doing these things. .. The medical report gives him a clean bill of health but he could not sustain these activities in repeated effort. [hearing 1]

The activity should be assessed in relation to completing a task:

> REPRESENTATIVE: Bending and kneeling - at the medical examination he got down but wavered and had difficulty getting back up. He could not complete a task while he was kneeling, or repeat a task involving kneeling. [hearing 7]

The activity should be assessed in relation to work:

> REPRESENTATIVE: The presenting officer said because he could manage in the house there's an inference that he could do these things. In the house you can take your time - it's not related to a work situation - he couldn't do a work task. There's not the same time and pressure in the house. It should be looked at from a work related point of view. [hearing 7]

The representative might ask the tribunal to interpret the descriptors more widely:

> REPRESENTATIVE: Mr S has insulin dependent diabetes which is not well controlled. He has no points for fits and blackouts. Mr S has 5 or 6 hypos a week.... I would argue that this comes under fits and blackouts. [hearing 8]

A common role for the representative was to explain why the evidence from the BAMS examination was inadequate or inaccurate:

> REPRESENTATIVE: The medical officer records that she can carry light shopping and suggests a pint of milk, bread and the paper. I would argue that this does not amount to the 2.5kg bag of potatoes necessary for this test. [hearing 13]

> REPRESENTATIVE: The doctor said if she was interested she could concentrate. She doesn't listen to the radio. She reads the newspaper. She used to enjoy reading and music. She does read the newspaper but jumps from one article to another. She cannot concentrate for long. [hearing 12]

Representatives had often, but not always, obtained additional medical evidence. In some cases the GP's evidence was essential for the success of the appeal:

> REPRESENTATIVE: There is a problem because Mrs M has no diagnosis but the letter from Dr J explains that she is still being investigated. She accepts the disabling symptoms but has made no diagnosis yet - it may be myasthenia gravis. [hearing 13]

> REPRESENTATIVE: The doctor confirms that he has had multiple falls, including a serious one last week when he fell down stairs. He is unable to sit on a chair for more than a few minutes, and he finds bending difficult. He has problems reading. [hearing 17]

One unrepresented appellant had brought further medical evidence along with her - and she won her appeal [hearing 3].

On other occasions the representative had gathered or emphasised evidence from other sources, for example the receipt of Disability Living Allowance as evidence of walking difficulties.[4]

Another source of evidence was the representative's own experience of the appellant's difficulties:

> REPRESENTATIVE: Mr S has 5 or 6 hypos a week. He had one coming on before we came in - he had to have a Mars bar. [hearing 8]
> WING MEMBER: [to appellant] Are you still driving?

[4] It has been argued that receipt of Disability Living Allowance mobility component should `passport' a claimant to Incapacity Benefit, because it confirms that the claimant is virtually unable to walk. However, this argument has not been accepted by the Government.

> APPELLANT: No. When I was, it was only maybe once a week. I picked and chose my time carefully. Now I don't drive at all.
> REPRESENTATIVE: If I can give an example. One time when he came to see me at my office, he had to choose the time very carefully, when there was no traffic. He couldn't reverse so he had to park where he could drive straight out. After that when I needed to see him I would go to his house. [hearing 17]

On other occasions the representative had encouraged a witness to attend. In these cases the tribunal would look to the witness for corroboration of the appellant's statements:

> REPRESENTATIVE: Walking - does she do a lot of walking?
> WITNESS: She can walk but only in her own time. Sometimes if I'm with her she gets left behind. I have to double back to go back to her.
> REPRESENTATIVE: How does she manage to the local shop?
> WITNESS: The shop is in the next street - I would take 3 or 4 minutes. It would take her maybe 8 minutes but it would take longer going back - going uphill. She would have to stop. [hearing 20]

Sometimes the representative corrected statements made by other participants in the tribunal, or reminded the tribunal of its role:

> CHAIR: Is it untreatable?
> REPRESENTATIVE: It doesn't matter whether it is treatable or not. The question is whether it exists. [hearing 12]

> REPRESENTATIVE: The presenting officer said that the tribunal should take the view of the BAMS doctor but I would argue that you should also look at what the claimant says. That's what the tribunal is for. It would be pointless if you just agreed with the BAMS doctor every time. I am not casting aspersions on the doctor but Mrs T had difficulty expressing herself during the examination. The tribunal is entitled to come to its own conclusion. [hearing 12]

It would perhaps be difficult for an unrepresented appellant to have this confidence.

A perspective on the effect of representation can be gleaned from what happened to unrepresented appellants. The opening statements by unrepresented appellants often showed that they had little idea of what was needed to win the appeal:

> APPELLANT: I just wanted sick pay - I wasn't looking for long term incapacity. Since then I've had an operation on this arm. I'd be happy to go for work but I'm not looking for long term incapacity. [hearing 5]

> APPELLANT: What I'd like to ask you is this. This is from last year - why is it I'm only getting £57 a fortnight. I've been on this for a few months. ... I don't know anything about points but I know what's wrong with my foot. [hearing 10]

In one case, information became available during the hearing which had not been considered up to that point:

> WING MEMBER: Have you ever considered working in an office?
> APPELLANT: No - sitting would be difficult - I don't think I could do an office job. [hearing 16]

This comment was not followed up by the tribunal or by the unrepresented appellant - `sitting' was not considered as a possible descriptor. It is possible that a representative would have picked this up.

The interview with an unrepresented appellant showed that he had little confidence in winning and did not really know how he could argue his case:

> I didn't really look at them [the appeal papers] - I just flicked through them.... I didn't really know what would happen. I didn't expect to win - I thought what the doctor said would go against me. To go from 0 points to 15 seemed a bit much to ask for. [interview, appellant 2]

This appellant reckoned that he would have done better with a representative and said that he would get one if the occasion arose again.

> If my back gets worse again I'll go back to my doctor and claim again.... Next time I'll approach it differently. I'll get someone from the Citizens Advice to help me - get someone to fight my corner. [interview, appellant 2]

The tribunal is supposed to consider whether the appellant met the requirements of the all work test at the time of the BAMS examination. This was an area where unrepresented appellants often misunderstood the law and emphasised how their difficulties had become worse:

> APPELLANT: There's no mention of my hip in last year's report. All you need to do is write to Dr J and he'll tell you. [hearing 10]

> WING MEMBER: At the medical you said you could walk 800 metres.
> APPELLANT: I could then but not now. [hearing 16]

Representatives on the other hand were aware of the requirements of the law:

> CHAIR: Can I confirm that we must look at his condition as it was in February? It could have deteriorated.
> REPRESENTATIVE: His condition has not deteriorated. There has not been much change since February. The situation has remained level. [hearing 17]

The evidence from hearings where the appellant was represented, unrepresented or not present shows that what is significant is the preparation of evidence and the presentation of the case so that it can be shown to fit within the rules. It would be wrong to argue that a skilled representative could make any case fit within the rules, but it is at least plausible that some of those who were unrepresented would have had a better chance if they had had the advice and support of a representative. This brings into question the effectiveness of the Benefits Agency procedures in collecting information at earlier stages.

The role of the medical assessor

The medical assessor is new to Social Security Appeal Tribunals. When Incapacity Benefit was introduced there was some debate as to who should hear appeals. There were arguments that there should be a doctor on the tribunal, and that this could be achieved by having appeals heard by Medical Appeal Tribunals, or Disability Appeal Tribunals (Bonner 1995, Wikeley 1995). However the Government insisted that Social Security Appeal Tribunals were the appropriate bodies because they were being asked to assess incapacity for work, not disability (Wikeley 1995). As a compromise the medical assessor was to be present so that a medical input could be made to the proceedings, but the medical assessor was not to take part in the decision making. Some concern was expressed that the role of the medical assessor was not clear (Bonner, Hooker and White 1995, p788, Wikeley 1995, p532).

Guidance from the Independent Tribunal Service says that the medical assessor should

> explain the meaning of medical terms; explain the significance of medication and possible side-effects; explain the normal progress of a condition; suggest further medical evidence that the tribunal might wish to ask for; suggest that the case should be referred to a BAMS doctor for possible exemption from the all work test.

The medical assessor should not participate in the decision making, give an opinion on what descriptor should apply, or ask questions (Poynter and Martin 1996, pp69-70).

Most tribunals used the medical assessor for the purposes described in the Independent Tribunal Service guidance. However, there were also several occasions when the medical assessor apparently overstepped this role.

In one case the tribunal had spent some time discussing whether or not the appellant had been diagnosed with a particular condition. The medical assessor offered an opinion on the appropriateness of this discussion:

> MEDICAL ASSESSOR: The tribunal should not be concerned with the diagnosis but with the disability. [hearing 13]

On another occasion the medical assessor suggested which would be the appropriate descriptor to apply:

> CHAIR: Do you have any observations on the mental health descriptors?
> MEDICAL ASSESSOR: I would say that descriptor Cpc [avoiding routine activities] might well be `yes' rather than `no' in the light of what the doctor has recorded. [hearing 12]

The medical assessor sometimes offered information during the course of the hearing without being asked:

> CHAIR: Mr P's own doctor doesn't say if there's any risk to his health.
> REPRESENTATIVE: Mr P is attending counselling for an alcohol problem and liver damage and depression.
> MEDICAL ASSESSOR: I can understand the GP's reluctance to comment on mental health. Mr P hasn't worked for several years and didn't have mental health problems when he was working. [hearing 9]

There were several examples of the medical assessor asking the appellant direct questions about the history or nature of his or her difficulties, sometimes in the course of answering a question from the chairman, but also unprompted:

> CHAIRMAN: [to appellant] Is there anything further you would like to tell us - anything we have not asked about?
> APPELLANT: No.
> CHAIRMAN: [to witness] Anything more you would like to say?
> WITNESS: No.
> MEDICAL ASSESSOR: Has your GP discussed your moods with you?
> APPELLANT: No. [hearing 20]

These examples suggest that the medical assessor does sometimes overstep the boundaries of the guidelines. Tribunal members, as well as presenting officers and representatives, often seek more from the assessor than the guidelines appear to permit:

> They are only there to give very general advice, not opinion. But that seems to be going away from the original intention. The chairman seems to be saying `do you have anything to comment?' `what do you think?' That's not what the medical assessor is for. [interview, presenting officer 1]

> They are not using the medical assessor very well - they are not asking him the right questions - they should be looking beyond just what the medication is. [interview, presenting officer 2]

> Most assessors do act only when spoken to, or if they do proffer advice they do it properly by saying to the chair `would it be possible for me to give you some advice at this stage'. I don't find anything improper about that so long as the chairman keeps control of the proceedings and decides that it is truly advisory and it is appropriate to make a comment at that stage. I think it is silly for the assessor to sit feeling very frustrated when he could be giving helpful advice. [interview, chairman 3]

The medical assessor has been described as a `talking medical dictionary' (Bonner, Hooker and White 1995, p788). It is clear that some assessors themselves find this role frustrating, because there is more that they would like to contribute.

One solution to this problem would be to have a doctor on the tribunal as a full member. Interviewees were asked if they thought there should be a medically qualified person on the tribunal. Some respondents thought that there should be, or that the appeals should heard by Disability Appeal Tribunals or Medical Appeal Tribunals:

> I am inclined to the view that DATs could do it better - it's not the same as DLA but it has some parallels. [interview, chairman 2]
>
> The format of the tribunal is not right. There should be a chairman who should be legally qualified but the other two members should be doctors. The one person who isn't there and whose evidence is torn to bits and who doesn't have a chance to reply is the BAMS doctor - he has a poor substitute in the adjudication officer who isn't medically qualified, doesn't read between the lines as to what he is saying, doesn't know what the best questions from a medical viewpoint would be. [interview, presenting officer 1]
>
> SSATs are the wrong vehicle - they should be MATs so that there is a doctor assessing appeals. The tribunals don't take enough account of the clinical examination. The medical assessor can give answers about medication such as whether it is a strong dose or not but they never ask what that means - for example maybe someone is on a strong dose but their doctor is trying to get them off it. They don't ask about that.... It's hard for the tribunal to assess a medical opinion when they are lay people. [interview, presenting officer 2]

On the other hand, some respondents were firmly of the belief that there should not be a doctor on the tribunal:

> It's not necessary - you need a medical person somewhere but I think the medical assessor is quite sufficient. I think it's a good thing that they're not on the tribunal - they would tend to come out with a medical view - they wouldn't change their view - that would be it, in their mind. [interview, chairman 1]
>
> I think the problem with that would be that the doctor would make up their mind before the tribunal goes ahead - based on the medical evidence - so that could count as a `no' vote. So long as the doctor is sitting at the end of the table and saying `it wouldn't normally be as bad as that' then that's not necessarily going to go against the claimant. I think it's quite fair the way it is. [interview, representative 2]
>
> I prefer to have the assessor giving us advice but it being purely advisory and not taking part in the decision making. I think that medical members can tend to dominate and that can always be a problem.... It's quite good to separate the two functions - to have his or her input on the medical matters ... and to have the social security tribunal come to their *own* decision regarding the credibility of the claimant and the other facts in the case. [interview, chairman 3]

The evidence suggests that the medical assessor's role is still unclear. The choice of the Social Security Appeal Tribunal with the medical assessor has not been shown to be more appropriate than the Disability Appeal Tribunal.

The success rate of appeals

Early figures suggest that a high proportion of appellants are winning their Incapacity Benefit appeals - at the end of January 1996 the success rate was 45% (Hansard, 18 March 1996, col 16).

The hearings observed followed this pattern, and interviewees confirmed that, in their experience, a high proportion of appeals were being upheld. The success rate can vary considerably depending on whether or not an appellant is present at the hearing and whether or not she or he has a representative. However, the high success rate suggests that tribunals are finding something that has been missed by the first tier decision makers in almost half the cases they hear. There are three possible explanations for this: the first tier decisions are wrong; the tribunal decisions are wrong; or there is something different about the two decisions. The evidence from this research suggests that it is the third of these explanations which is most likely.

Genn argues that a high level of appeals being upheld indicates that there are problems with initial decisions. However, she qualifies this by saying that poor decisions are often caused by inadequate information (Genn 1994, p269).

The initial decision may be `correct', given the information the adjudication officer has available - but the tribunal is justified in overturning it because it has fuller information. Interviewees confirmed that inadequate information at the first stage was the most likely reason for the success of appeals:

> If there isn't enough information on the claim pack, then the medical examination is going to be conducted from a limited base - and the adjudication officer is picking up from that - so their decision is being based on a lack of information from the claimant in the first instance. [interview, representative 1]

> I think the AO [adjudication officer] decision is made at a very early stage in the process before the claimant realises what it is all about - before they marshal their evidence properly. It probably is a correct decision at the time that the AO made it - but when you look at all the evidence, you come to a different decision. [interview, chairman 1]
>
> The AO does usually act on the advice of the BAMS doctor. I can't say I blame the adjudication officer for making the decision in the way he has, based on the doctor's report. Given the way that the information is collected - I don't really see that the decisions are wrong on the evidence. [interview, chairman 3]

In addition the appeal tribunal may be more likely to consider a wider interpretation of the rules, particularly if there is a representative to remind them of this.

One presenting officer believed that tribunals' decision making was at fault:

> They [tribunals] are a farce - because you have a system where everybody knows how many points are attached to a certain condition. It's quite easy just to look at that and decide beforehand `right we have 6 points, here is where we can get points for other things' and then go along and say `I can't do this, I can't do that' and get the points awarded and the tribunal just accept that. I've yet to see a tribunal that pays much attention to the medical evidence. [interview, presenting officer 1]

I asked this presenting officer if that suggested that the Benefits Agency should be appealing tribunal decisions to the social security commissioners. The answer was revealing about Incapacity Benefit as a whole:

> There are a lot of cases waiting to go to the commissioners but the trouble is that's only on a point of law - someone's opinion as to whether someone's unfit for work, that's not really a point of law. [interview, presenting officer 1]

The presenting officer had picked up on one of the major issues surrounding Incapacity Benefit: that the supposedly objective test still contains a considerable element of subjectivity. Two of the chairmen saw this as an explanation for the high success rate of claimants' appeals:

> We thought we would be very hamstrung - but in fact they are not so cut and dried as they seem. Within the parameters of the test it is not the case that we are given no leeway - assessing the information, coming to a decision about how a descriptor applies to a particular claimant, that does leave us room for an independent function. [interview, chairman 3]

> Either BAMS doctors are following a heavy line and consciously marking people down, or we are doing the opposite, or there is simply a different view. The Secretary of State had this idea that there would be this wonderful schedule and it would be cut and dried, straightforward, therefore a clear position of people either get it or don't get it but with real people it's far from clear - it's a value judgement and one person's judgement can be quite different from another. [interview, chairman 2]

The suitability of the all work test in assessing incapacity for work

Is the all work test effective in assessing a claimant's fitness for work? There is no doubt that some of the people who appealed would have found it extremely difficult, if not impossible, to get and hold down a job. It is more difficult to assess whether those who won their appeals were less able to work than those who lost.

Appellants, in particular, often stressed the practical difficulties of getting or doing a job:

> WING MEMBER: Is it the variability of your condition that makes you feel you couldn't do a job of any sort?
> APPELLANT: Yes - some days I'm as good as new and then I could be on my back for weeks.
> WING MEMBER: So that's what would worry you about working?
> APPELLANT: Yes - I'd be unhappy taking a job, then losing it because I couldn't do it. And with lifting - if you're lifting something with another person you're putting them at risk if you dropped it - it would be dangerous. [hearing 16]

> APPELLANT: I was forced to stop after working for 18 years. I'm under the disablement officer but he can't find me anything. There's not much you can do without using your arms. [hearing 5]

In most cases, the tribunals appeared to be following the letter of the law and adding up the points before deciding whether someone was fit for work. Whether or not they were also first of all making an unconscious common sense assessment of the person's capacity for work is impossible to prove. However, there was one case where this appeared to be happening:

> PRESENTING OFFICER: I think Mr H is ill enough. I'm sure his representative will manage to increase his points to 15 without difficulty.
> CHAIR: Point us to the descriptors we should follow.
> REPRESENTATIVE: 1c - unable to walk 50 metres - that's 15 points. Unable to climb stairs without stopping....
> WING MEMBER: Do you have to use your inhaler when you go up stairs?
> APPELLANT: Yes.
> WING MEMBER: Presumably you have to stop to use it?
> CHAIR: I'm happy that Mr H satisfies 1c [asks wing members if they agree - they do]. That's 15 points. [hearing 2]

Tribunal chairmen argued that they did add up the points first, but that there were occasions when a person was clearly unable to work. In these cases they would `take care to make sure that we had covered everything' [interview, chairman 2], `scratch around the criteria', [interview, chairman 1] or `explore all the descriptors to ensure that there wasn't one where we could get 15 points' [interview, chairman 3].

Interviewees were critical of aspects of the all work test and felt that there were some people who would have difficulty meeting its requirements. Most of them however felt that it was not as bad as they had expected it to be, and that it had positive aspects:

> That idea of trying to assess someone's incapacity on that kind of tangible basis - there's an argument perhaps that it could be more than 15 points, or less, or maybe whether you *should* have a magic figure at all, but I think anything other than the old system must be an improvement. It wasn't working. That's not to say that this is working either. [interview, presenting officer 1]

> Especially with older people - if they can't read or write, for example, that should be taken into account. If they've always worked in manual work - someone I've met who's worked hard all their life in physical labour and he's damaged his back - for someone like that, physically he's not unfit for work but the only work he can actually do is manual work. He can't read and write - he gets one of his school age children to tell him what the forms say - how can he really be expected to walk into a job centre and take whatever they offer? At least with Invalidity Benefit they did take account of people's experience. [interview, representative 1]

> I always preferred the old Invalidity Benefit - general global issues - you weren't just looking at medical issues but you were looking at background, education and capacity to hold down a job. It [the all work test] has some advantages - it's more straightforward - for example the virtually unable to walk, you give it to them straight away. The mental aspect is sometimes easier to assess but then again it can be difficult - people don't usually have a cut and dried psychiatric assessment. [interview, chairman 2]

An alternative is for the tribunal to use Regulation 27 (that the person has a severe uncontrolled or uncontrollable disease) as a let out clause. One chairman discussed this as an alternative when the tribunal felt that the appellant was incapable of work but did not fit well into the all work test:

> [If] the tribunal was satisfied that the claimant was genuine and having real problems which prevented them from doing any kind of work then ... we have either fitted them into the descriptors or, where that was not right to do that, we have thought that surely Reg 27 must apply and referred it back. [interview, chairman 3]

The tribunal itself cannot uphold the appeal under this regulation but must refer the claim back to the BAMS doctor. There were no cases in this research where this happened. However, there were two hearings where the case had already been adjourned for this reason and the tribunal was considering the new evidence. Both of these cases were unsatisfactory: one because the decision of the original adjourned tribunal had not made it clear enough what further evidence was required, and from whom [hearing 2]; and the other because the appellant had to be put through the anxiety of a second hearing over a point which was by that time agreed by all concerned [hearing 15].

This confirms the concern that Regulation 27 is of some use as a general safety net but that its application is clumsy and it is easy for people to fall through it.

The all work test appears to be not as disastrous for claimants as commentators predicted it would be, at least for people who make it to an appeal tribunal with the backing of an experienced representative. As one chairman put it: `I'm very glad the tribunals are there' [interview, chairman 1]. However, we should ask whether a system which depends on appeals to sort out problems is an effective one.

Chapter 6
CONCLUSION

This conclusion covers three main areas. The first focuses on some of the more technical procedures of the initial assessment to Incapacity Benefit. From there it is natural to move on to consider the role of tribunals in policing the system. Finally, I examine the system as a whole and ask how far Incapacity Benefit is achieving what it was set up to do.

Procedures for assessing claimants under the all work test

The research showed that there were a number of practical problems in the procedures for assessing claimants in the areas looked at.

The questionnaire

The questionnaire closely follows the all work test descriptors, so that people who do not clearly fit into the descriptors have difficulty filling it in. These people may nevertheless qualify for benefit if their difficulties are described in greater detail, following the Benefits Agency guidelines on interpretation of the descriptors. The form has an introductory section which asks people to describe how pain, tiredness and breathlessness, affects what they can do (Benefits Agency 1995b, p3). One way of improving the form would be to repeat this request throughout the form to encourage people to give a fuller picture of their difficulties.

Respondents highlighted the particular inadequacy of the form for people with mental health difficulties. The form could be redesigned to make this section more prominent and to ask more explicit questions about how mental health difficulties affect the claimant's day-to-day life.

The problem of form-filling is inherent in a system which relies on `self-assessment' as a starting point for the claim. It could be alleviated by providing help with filling in the forms. The Benefits Agency could provide more help with form filling but claimants would not necessarily trust advice which was not independent. The recent closure of the Benefits Agency freephone services (CPAG 1996) shows a reduction rather than an expansion in advisory services to claimants.

The BAMS examination should be able to pick up anything that has been missed by the questionnaire, but BAMS doctors tend to use the questionnaire as a starting point and do not go beyond what the claimant has already written.

Advice agencies can help people with claim forms, but this research suggests that people do not normally contact advice agencies for help until after the BAMS examination, rather than when they get the form. Additional publicity by advice agencies would perhaps encourage people to contact them at an earlier stage. But advice agencies are already underfunded and overstretched. The cost of help from advice agencies should be included in the assessment of the costs of Incapacity Benefit.

BAMS examinations

Problems with BAMS examinations focused on the time spent with each claimant, and the fact that not all doctors were following the Benefits Agency guidelines on the interpretation of the descriptors. A fairer system would allow doctors to spend more time with claimants, which would enable them to obtain information from claimants who had found difficulty with the form, and to explore any areas of dispute in more detail. Greater emphasis on the guidelines would enable BAMS doctors to make better assessments of people whose conditions do not appear, on the surface, to fit easily into the descriptors.

Spending more time with claimants would increase the cost of assessments for Incapacity Benefit. However, it would perhaps be more efficient to put more time into claims at this stage, rather than having people refused benefit and the decisions being overturned by a more expensive appeals system.

A recent press report showed that there was a wide variation in the rate at which people were refused benefit after the BAMS examinations, varying from 3% rejection in some parts of Scotland, to 22% in others (*Daily Mail*, 14 August 1996). Further research on BAMS examinations is needed to find out why there is this variation, and to find out to what extent doctors are following Benefits Agency guidelines.

The role of the GP

More use should be made of the GP. The indications are that, in trying to cut down the role of the GP, the Government has undervalued an important source of knowledge about the claimant's

difficulties. More of the GP's evidence could be used to give a broader picture, particularly when there is a discrepancy between the claimant's statement and the findings of the BAMS doctor. The Government needs to get away from assuming that GPs distort the truth to help claimants. The GP's evidence is considered appropriate for other claims (eg Disability Living Allowance); there is no reason to assume that it should be less valid for Incapacity Benefit. Further research would be desirable to show how GPs themselves are finding the new system, and how they react to their patients being refused benefit.

Tribunals

Appeal tribunals appear to be counteracting some of the initial problems with the assessment process, but only if the appellant is present at the hearing, and preferably if the appellant has a representative. Tribunals compensate for the inadequacy of information collected by the assessment process in several ways: spending more time with the appellant, hearing evidence direct from the appellant, considering extra medical evidence provided by the appellant, taking the advice of the medical assessor, and addressing any legal points made by the appellant's representative. When some tribunal members consider on common sense grounds that the appellant is genuinely unfit for work, they will pursue every possible avenue that might fit the appellant into the all work test.

The question is whether this system is a reasonable means of assessing claims for benefit. There is an argument that it is reasonable because everyone has a chance of appealing. If the adjudication officer gets it wrong first time, claimants have not lost anything. But this depends on claimants exercising their right of appeal. There is an assumption that those who do not appeal do not have good cases, or do not care about the result. No doubt this is true for some people, but research evidence suggests that people's reasons for not appealing are more complex than this, and that we cannot assume that they all have `hopeless' cases (Baldwin, Wikeley and Young 1992, p107, Genn 1994, p266).

The chances of an appeal succeeding are also not wholly based on how unfit for work the claimant is, since outcomes are affected by the appellant being present at the hearing, and whether or not she or he has a representative. Those who eventually succeed with their appeals

are put through considerable distress and worry, as well as having a reduced income prior to the appeal.

It has been argued that the justice of a decision making system lies in the system as a whole. We cannot judge it by looking only at appeals, since it must be fair at every level (Adler 1991). The procedures should be improved to ensure that claimants get a fair assessment first time round.

There is a second consideration: whether a system which depends so heavily on appeals is an efficient means of assessing benefit. Mashaw argues that the primary concern of a bureaucratic system is `to develop at the least possible cost a system for distinguishing between true and false claims' (Mashaw 1983, p24). A claim which is decided in a claimant's favour is considerably more expensive if it has been processed through the appeals system than one which has been allowed by the adjudication officer. There is an argument that putting more resources into first stage claims would be more efficient in the long run. This idea has been picked up by the Government in its recent review of decision making and appeals (DSS 1996). However, this review seems likely to cut back claimants' right of redress without necessarily ensuring that their claims are properly assessed in the first place. What is needed is a system which is better at making initial assessments, but which also preserves the claimant's right to a full appeal.

The role of the medical assessor

Some medical input is essential in enabling the tribunal to come to a decision on medical matters. It is not clear however that the medical assessor is the best means of achieving this. There is a strong case that there should be a doctor on the tribunal itself, although some have expressed reservations about this. The Government's reasons for choosing the current composition of tribunals were largely to do with the politics of Incapacity Benefit. The suitability of the medical assessor should be considered in more detail, perhaps with a comparative study of the role of doctors on Disability Appeal Tribunals.

The all work test

Effect on claimants

The all work test has proved not to be as ruthless as was initially anticipated. Government predictions about the number of people who would be refused benefit turned out to be over-estimates: 33,580 people who had previously qualified for Invalidity Benefit, and 6,780 new claimants, were found fit for work during the first year, compared with Government predictions of 220,000 and 55,000 in the first two years (Hansard, 23 April 1996, col 134). An explanation for these figures is difficult to find. One possibility is that the all work test is a better test of capacity for work than most critics originally thought. One of the criticisms of the test was that it abandoned discretion and replaced it with a system of rigid rules, but it seems that it is not completely rigid. There do seem to be ways in which people can fit into it even if, on the surface, their disabilities do not seem to match the descriptors. However, this only happens if sufficient information is collected about their difficulties and if decision makers apply the guidelines laid down by the Benefits Agency. If enough attention is given to individual claims there is more flexibility in the all work test than was originally considered.

A second criticism of the all work test was that it cut out the `social' reasons for incapacity for work in order to concentrate on the purely medical aspects. However, it seems that it is difficult to make this distinction in any meaningful way. It is possible that the all work test does somehow pick up `social' disabilities. What is clear is that the Government has been proved wrong in its assumption that a considerable proportion of Invalidity Benefit recipients were malingerers.

However, we know that there are some people who were considered unfit for work under the old Invalidity Benefit test who do `fail' the Incapacity Benefit test. Perhaps some of these people were not as ill as had been assumed. Or perhaps some failed because of deficiencies in the initial assessment process, but if they had appealed these might have been rectified. Further information about those who are ultimately refused benefit would tell us if there is a pattern in the refusals, and who or what it is that the all work test excludes.

One of the concerns about the test was that it would create people who were considered capable of work by one system (Incapacity Benefit) but incapable by another (Unemployment Benefit, or Jobseeker's Allowance from October 1996) and that these people would fall through a hole in the social security system and be left with nothing. Research on the overlap between Invalidity Benefit and Unemployment Benefit showed that some people did fall foul of both sets of rules (RADAR 1994). Figures show that less than half of those refused Incapacity Benefit

signed on as unemployed, and no information is available about what happened to the others (Howard 1996). Further research is needed to find out what does happen to these people, and, once Jobseeker's Allowance is in place, whether there are more holes in the system and who is in danger of falling through them.

A policy disaster?

The all work test was forecast to be bad news for claimants and a `disaster of Child Support Agency proportions' for the Government (Bonner 1995, p112). There has not been the public outcry that was expected, but that may be because the test was carefully designed to ensure that the most deserving disabled people were covered by exemption clauses. The low rate of refusals will have prevented the mass protest that was forecast. It is also possible that tribunals prevent the very worst injustices created by the all work test from having their full effect, while being unable to help those whose circumstances are not so distressing. This would support the view that one of the roles of tribunals is to legitimate unacceptable government actions, by controlling protest (Prosser 1977).

However, as a policy for cutting expenditure, the all work test has failed: the numbers of people being refused have not been high enough to produce planned savings.[5] How has the Government reacted to this? There are no signs that the Government will respond by making further cuts in eligibility for Incapacity Benefit. The introduction of the all work test was accompanied by statements about how carefully it had been designed and tested. It would be difficult politically for the Government to decide that the threshold for incapacity for work was now 20 points instead of 15. There was a statement in April 1996 that changes would be made to the administration of Incapacity Benefit but these were pilot projects and no details were given (Hansard, 2 April 1996, col 217).

The Government's recent review of adjudication and appeals (DSS 1996) has clearly been influenced by the experience of Incapacity Benefit appeals. In particular the paper contains the proposal that tribunals should not make decisions on the basis of new medical evidence, but instead should adjourn to enable the evidence to be considered by a first line adjudicator (DSS

[5] Other changes that were made in payment levels, and taxation, of Incapacity Benefit will take longer to produce savings because existing claimants had their benefit levels protected and had transitional protection from taxation (Transitional Regs).

1996, p15). The collection of evidence has been identified as the main problem with the assessment process. If tribunals were unable to consider new evidence this would seriously undermine their ability to give appellants a fair hearing.

Weighing up the bag of potatoes test

This leads us back to the question of what the all work test measures. It was not designed to assess capacity for work as such, but to identify a level of disability at which it was not `reasonable' to expect people to work. The social security system has always made a clear distinction on paper between those who are unemployed and those who are unable to work through illness or disability. We have seen that this distinction is not as clear in the real world: a considerable part of a person's capacity for work is determined by the jobs available. Incapacity for work and unemployment are inextricably linked.

What seems to have happened is that the Government was aware that cuts in Invalidity Benefit would be politically awkward, and sought to justify the cuts by appealing to the public's view of social security benefit recipients as being either 'deserving' or 'undeserving' (Wikeley 1995). Writers have recognised the importance of stigma among the reasons for the increase in claims for Invalidity Benefit: it is more socially acceptable to be sick than to be unemployed (Piachaud 1986, Mashaw 1983, p54). The distinction between incapacity and unemployment is encouraged by the Government for political reasons and is reflected in the different levels of payment for incapacity and unemployment benefits. By suggesting that some claimants were not really sick the Government tried to change their image from deserving to undeserving.

It would not have been possible to label all claimants of Invalidity Benefit in this way, and deserving categories of disabled people had their status protected through the exemption regulations. By casting some Invalidity Benefit claimants in the role of 'undeserving', the Government was able to make moves to cut a potentially sensitive area of spending. The fact that most claimants have proved to be deserving after all is a problem for the Government, but it is also a problem for those others who have crossed the line to find themselves labelled as undeserving. To ensure an open political debate on what constitutes an acceptable test, we need clear information about the people who fail the test, and why. Continued research on the operation of the all work test, and its effects on claimants, will contribute to that debate.

Do we believe that the ability to lift a bag of potatoes, or to put on a hat, or to walk down stairs sideways, is a fair reflection of ability to work? It may be that the criteria in the all work test do reflect this, or at least establish a level of disability at which society is prepared to pay benefits - though no doubt the debate on this will continue. If so, however, we need to ensure that this is in fact what the test measures. At the moment the test also measures the ability to fill in the form, the visibility of the claimant's disability and the time and effort put in by the BAMS doctor. These elements of a claim vary arbitrarily from one claimant to the next. For Incapacity Benefit to succeed politically, the assessment procedures have to be seen to be fair and consistent. It is not clear that they are.

Appendix 1
The All Work Test

Schedule to Regulation 6(1)(b) 24 of the ICB Regulations

Part 1 - Physical Disabilities

Activity	Descriptor	points
1. Walking on level ground with a walking stick or other aid if such aid is normally used.	(a) Cannot walk at all.	15
	(b) Cannot walk more than few steps without stopping or severe discomfort.	15
	(c) Cannot walk more than 50 metres without stopping or severe discomfort.	15
	(d) Cannot walk more than 200 metres without stopping or severe discomfort.	7
	(e) Cannot walk more than 400 metres without stopping or severe discomfort.	3
	(f) Cannot walk more than 800 metres without stopping or severe discomfort.	0
	(g) No walking problem.	0
2. Walking up and down stairs.	(a) Cannot walk up and down one stair.	15
	(b) Cannot walk up and down a flight of 12 stairs.	15
	(c) Cannot walk up and down a flight of 12 stairs without taking a rest.	7
	(d) Cannot walk up and down a flight of 12 stairs without holding on.	3
	(e) Cannot walk up and down a flight of 12 stairs if he goes sideways or one step at a time.	3
	(f) No problem in walking up and down stairs.	0
3. Sitting in an upright chair with a back but no arms.	(a) Cannot sit comfortably.	15
	(b) Cannot sit comfortably for more than 10 minutes without having to move from the chair.	15
	(c) Cannot sit comfortably for more than 30 minutes without having to move from the chair.	7
	(d) Cannot sit comfortably for more than an hour without having to move from the chair.	3
	(e) Cannot sit comfortably for more than two	

	hours without having to move from the chair.	
	(f) No problem with sitting	0
4. Standing without the support of another person or the use of an aid except a walking stick.	(a) Cannot stand unassisted	
	(b) Cannot stand for more than a minute before needing to sit down.	0
	(c) Cannot stand for more than 10 minutes before needing to sit down.	15
	(d) Cannot stand for more than 30 minutes before needing to sit down.	15
	(e) Cannot stand for more than 10 minutes before needing to move around.	15
	(f) Cannot stand for more than 30 minutes before needing to move around.	7
	(g) No problems standing	7
5. Rising from sitting in an upright chair with a back but no arms without the help of another person.	(a) Cannot rise from sitting to standing.	3
	(b) Cannot rise from sitting to standing without holding on to something.	0
	(c) Sometimes cannot rise from sitting to standing without holding on to something.	15
	(d) No problem with rising from sitting to standing.	7
6. Bending and kneeling.	(a) Cannot bend to touch his knees and straighten up again.	3
	(b) Cannot bend or kneel as if to pick up a piece of paper from the floor and straighten up again.	0
	(c) Sometimes cannot bend or kneel as if to pick up a piece of paper from the floor and straighten up again.	15
	(d) No problems with bending or kneeling.	15
7. Manual dexterity.	(a) Cannot turn the pages of a book with either hand.	3
	(b) Cannot turn a tap or control knobs on a cooker with either hand.	0
	(c) Cannot pick up a coin which is 2.5 centimetres or less in diameter with either hand.	15
	(d) Cannot use a pen or pencil.	15
	(e) Cannot tie a bow in laces or string.	15
	(f) Cannot turn a tap or control knobs on a cooker with one hand.	15
	(g) Cannot pick up a coin which is 2.5 centimetres or less in diameter with one hand.	10

		(h) No problems with manual dexterity.	6
8.	Lifting and carrying.	(a) Cannot pick up a paper-back book with either hand.	6
		(b) Cannot pick up and carry a 0.5 litre carton of milk with either hand.	0
		(c) Cannot pick up and pour from a full saucepan or kettle of 1.7 litre capacity with either hand.	15
		(d) Cannot pick up and carry a 2.5 kilogramme bag of potatoes with either hand.	15
		(e) Cannot pick up and carry a 0.5 litre carton of milk with one hand.	15
		(f) Cannot pick up and carry a 2.5 kilogramme bag of potatoes with one hand.	
		(g) No problems lifting and carrying.	8
9.	Reaching	(a) Cannot raise either arm to put something in the top pocket of a coat or jacket.	6
		(b) Cannot raise either arm to his head to put on a hat.	0
		(c) Cannot put either arm behind back to put on a coat or jacket.	0
		(d) Cannot raise either arm above his head to reach for something.	15
		(e) Cannot raise one arm to his head to put on a hat.	15
		(f) Cannot raise one arm above his head to reach for something.	15
		(g) No problems with reaching.	15
10.	Speech	(a) Cannot speak.	6
		(b) Speech cannot be understood by family or friends.	0
		(c) Speech cannot be understood by strangers.	
		(d) Strangers have great difficulty understanding speech.	0
		(e) Strangers have some difficulty understanding speech.	15
		(f) No problems with speech.	15
		(a) Cannot hear sounds at all.	15
		(b) Cannot hear well enough to follow a television programme with the volume turned up.	10

11. Hearing with a hearing aid or other aid if normally worn.	(c) Cannot hear well enough to understand someone talking in a loud voice in a quiet room.	8
	(d) Cannot hear well enough to understand someone talking in a normal voice in a quiet room.	0
	(e) Cannot hear well enough to understand someone talking in a normal voice on a busy street.	15
	(f) No problem with hearing.	15
		10
12. Vision in normal daylight or bright electric light with glasses or other aid to vision if such aid is normally worn.	(a) Cannot tell light from dark.	
	(b) Cannot see the shape of furniture in the room.	8
	(c) Cannot see well enough to read 16 point print at a distance greater than 20 centimetres.	0
	(d) Cannot see well enough to recognise a friend across the room.	15
	(e) Cannot see well enough to recognise a friend across the road.	15
	(f) No problem with vision.	15
13. Continence	(a) No voluntary control over bowels.	
	(b) No voluntary control over bladder.	
	(c) Loses control of bowels at least once a week.	12
	(d) Loses control of bowels at least once a month.	8
	(e) Loses control of bowels occasionally.	0
	(f) Loses control of bladder at least once a month.	15
	(g) Loses control of bladder occasionally.	15
	(h) No problem with continence.	15
14. Remaining conscious other than for normal periods of sleep.	(a) Has an involuntary episode of lost or altered consciousness at least once a day.	15
	(b) Has an involuntary episode of lost or altered consciousness at least once a week.	9
	(c) Has an involuntary episode of lost or altered consciousness at least once a month.	3
	(d) Has had an involuntary episode of lost or altered consciousness at least twice in the 6 months before the day in respect to which it falls to be determined whether he is incapable of work for the purpose of entitlement to any	0
		0
		15
		15

		benefit, allowance or advantage.	15
		(e) Has had an involuntary episode of lost or altered consciousness at least once in the 6 months before the day in respect to which it falls to be determined whether he is incapable of work for the purpose of entitlement to any benefit, allowance or advantage.	12
		(f) Has had an involuntary episode of lost or altered consciousness at least once in the three years before the day in respect to which it falls to be determined whether he is incapable of work for the purpose of entitlement to any benefit, allowance or advantage.	8
		(g) Has no problems with consciousness.	0

Part 2 Mental disabilities

15.	Completion of tasks.	(a) Cannot answer the telephone and reliably take a message.	2
		(b) Often sits for hours doing nothing.	2
		(c) Cannot concentrate to read a magazine article or follow a radio programme.	1
		(d) Cannot use a telephone book or other directory to find a number.	1
		(e) Mental condition prevents him from undertaking leisure activities previously enjoyed.	1
		(f) Overlooks or forgets the risk posed by domestic appliances or other common hazards due to poor concentration.	1
		(g) Agitation, confusion or forgetfulness has resulted in mishaps or accidents in the 3	1

		months before the day in respect to which it falls to be determined whether he is incapable of work for the purpose of entitlement to any benefit, allowance or advantage.	
		(h) Concentration can only be sustained by prompting.	1
16.	Daily living.	(a) Needs encouragement to get up and dress.	
		(b) Needs alcohol before midday.	
		(c) Is frequently distressed at some time of the day due to fluctuation of mood.	2
		(d) Does not care about his appearance and living conditions.	2 1
		(e) Sleep problems interfere with his daytime activities.	1
17.	Coping with pressure.	(a) Mental stress was a factor in making him stop work.	1
		(b) Frequently feels scared or panicky for no obvious reason.	2
		(c) Avoids carrying out routine activities because he is convinced they will prove too tiring or stressful.	2
		(d) Is unable to cope with changes in daily routine.	1
		(e) Frequently finds there are so many things to do that he gives up because of fatigue apathy or disinterest.	1
		(f) Is scared or anxious that work would bring back or worsen his illness.	1
18.	Interaction with other people.	(a) Cannot look after himself without help from others.	1
		(b) Gets upset by ordinary events and it results in disruptive behavioural problems.	2
		(c) Mental problems impair ability to communicate with other people.	2
		(d) Gets irritated by things that would not have bothered him before he became ill.	2
		(e) Prefers to be left alone for 6 hours or more each day.	1
		(f) Is too frightened to go out alone.	1 1

Exemptions from the all work test

Regulation 10 of the ICB Regulations

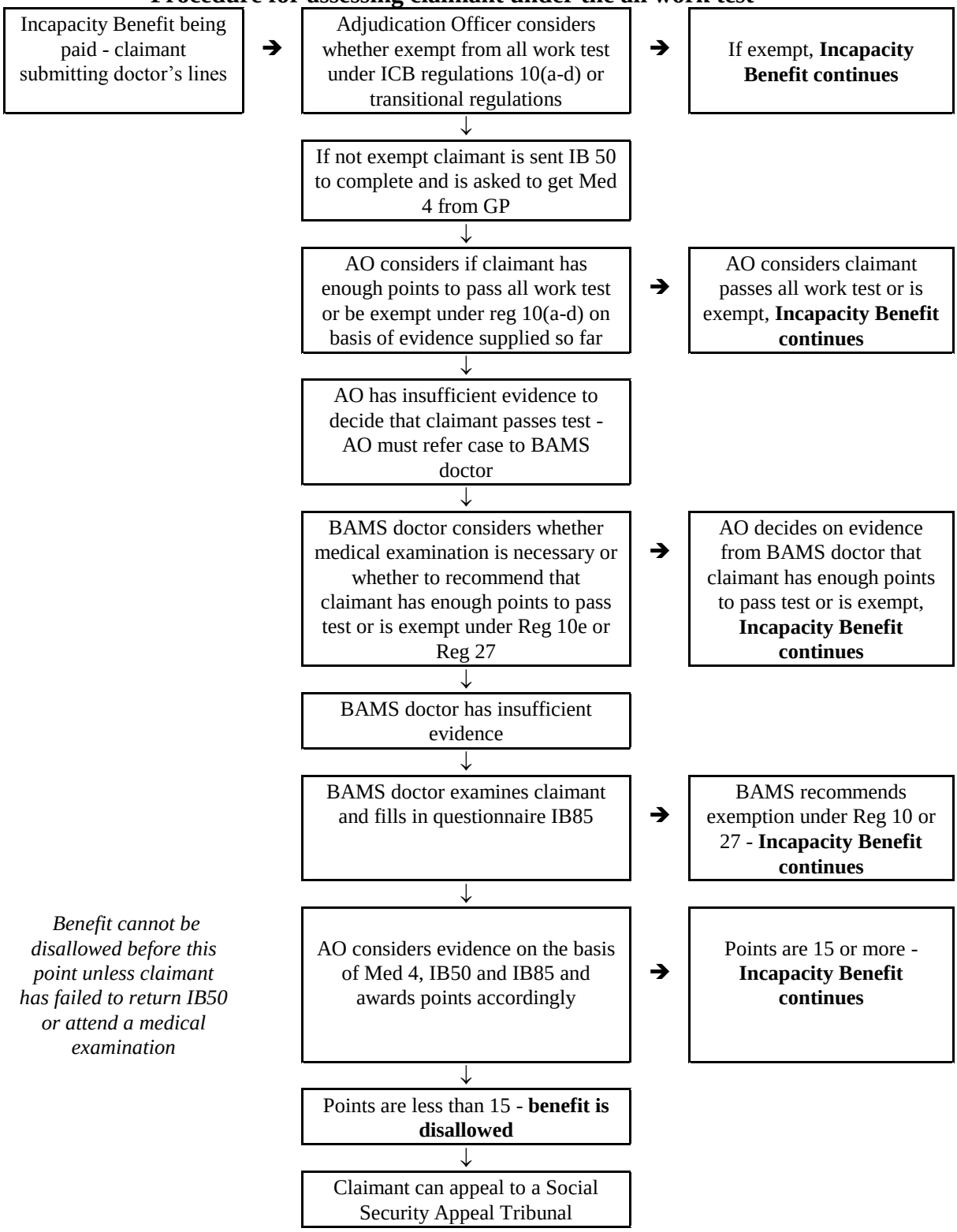
People are 'treated as incapable of work' and are exempt from the all work test if they:

(10a-d)
- recieve the highest rate care component of Disability Living Allowance; or
- suffer from a terminal illness; or
- are registered blind; or
- have tetraplegia; or
- are in a persistent vegetative state; or
- have dementia; or
- have paraplegia or similar conditions making them effectively paraplegic; or

(10e)
- have a severe learning disability; or
- have a severe and progressive neurological and muscle wasting disease; or
- have an active form of polyarthritis; or
- have a progressive impairment of cardio-respiratory function; or
- have dense paralysis of the upper limb, trunk and lower limb on one side of the body; or
- have a multiple impairment of function of the brain or nervous system causing severe and irreversible motor, sensory and intellectual deficits; or
- have a severe and progressive immune deficiency state; or
- have a severe mental illness.

People in the categories in regulation 10e can only be exempted if their condition is verified by a BAMS doctor.

Appendix 2
Procedure for assessing claimant under the all work test



Based on information from Bonner, Hooker and White 1995, pp 790-792.

Appendix 3
Appellant characteristics

Gender

men	14
women	6

Age

	men	women	total
20-29	0	1	1
30-39	1	2	3
40-49	2	1	3
50-59	9	2	11
not known	2	0	2

Type of Disability

	Men	Women	Total
1 Musculo-skeletal /back pain	7	3	10
2 Arthritis	3	0	3
3 Mental health problem	1	1	2
4 Circulation or heart or lung problem	3	0	3
5 Others	4	3	7

`Others' includes bowel problems, diabetes, dermatitis, visual impairment, severe headaches, neurological problems. Total number of disabilities is greater than the number of appellants because some people had more than one main disability.

Length of claim

Since April 1995 (new Incapacity Benefit claim)	5
Before April 1995 (reviewed Invalidity Benefit claim)	15

Appendix 4
Tribunal hearing characteristics

Participants
20 appellants
6 chairs
6 presenting officers
9 representatives
11 wing members
5 medical assessors

Length
Average length of hearing 23 minutes
Shortest hearing 5 minutes
Longest hearing 60 minutes.
Average length of adjournment 13 minutes
Shortest adjournment - decision given during hearing
Longest adjournment 25 minutes

Representation
12 represented
8 unrepresented
3 appellants not present and unrepresented
Types of representative 10 local authority welfare rights officers
2 Citizens Advice Bureau volunteers

Appeal results
12 appeals upheld
5 appeals overturned
3 not known

Combination of presence of appellant, representation and appeal results

	Successful	Unsuccessful
Appellant present and represented	11	1
Appellant present and unrepresented	1	4
Appellant not present		3*

*The actual result of these is not known, but from the information gained at the hearing, it is highly unlikely that they could have won.

Results of hearing given the same day
In all but two of the hearings when the appellant was present, the chairman invited the appellant back after the adjournment to tell her or him the result. On the two occasions when the chairman did not invite the appellant back, the appellant was unrepresented and had lost his or her appeal. On two occasions the tribunal agreed to uphold the appeal during the main part of the hearing, without the need for an adjournment.

Characteristics of individual hearings

Hearing No	Disability	Age	F/M	review/new	app there	chair	rep	medass	pres. officer	time mins.	adjourn mins.	points-before	points-after	Result
1	musc-skel	50+	M	review	yes	A	A	A	A	35	10	0	16	Win
2	heart/lung	50+	M	review	yes	A	B	A	B	25	none	6	15+	Win
3	other	20+	F	review	yes	A	none	A	B	20	5	10	25	Win
4	musc-skel/mh	40+	M	review	yes	A	C	B	C	60	15	6	9	Lose
5	musc-skel	50+	F	new	yes	A	none	B	C	12	N/K	0	N/K	Lose
6	musc-skel	50+	M	new	yes	A	none	B	C	15	N/K	6	N/K	Lose
7	arth/other	50+	M	review	yes	A	D	B	D	17	12	8	26	Win
8	arth/other	40+	M	review	yes	A	D	B	D	25	7	0	21	Win
9	other	50+	M	review	yes	A	D	B	D	18	12	6	21	Win
10	musc-skel	50+	M	new	yes	B	none	A	C	23	12	0	0	Lose
11	musc-skel	N/K	M	review	no	B	none	A	C	5	N/K	0	0	Lose*
12	mh/other	50+	F	review	yes	B	E	A	C	45	15	12	19	Win
13	Other	30+	F	new	yes	B	E	A	C	40	25	6	42	Win
14	Arth	50+	M	review	yes	C	F	C	C	18	12	12	27	Win
15	heart/lung	50+	M	review	yes	C	G	C	C	5	none	N/K	exempt	Win

16	musc-skel	30+	M	review	yes	D	none	D	E	13	11	0	7	Lose
17	heart/lung/other	50+	M	review	yes	D	H	D	E	21	13	7	27	Win
18	musc-skel	30+	F	new	no	E	none	E	F	9	N/K	N/K	N/K	Lose*
19	musc-skel	N/K	M	review	no	E	none	E	F	13	N/K	N/K	N/K	Lose*
20	musc-skel	40+	F	review	yes	E	I	E	F	52	18	12	31	Win

Notes to table of characteristics of individual hearings

Disability - the disabilities listed correspond to the categories in appendix 3.

Review/new - indicates whether the claim was an old Invalidity Benefit claim being reviewed under the new regulations or new claim which was made since April 1995.

App there - indicates whethere or not the appellant was present at the hearing.

Details of chair, representative, medical assessor and presenting officer - letters depict different individuals filling this role.

Time - indicates the length of the hearing

Adjourn - indicates the length of the adjournment

N/K indicates that the information was not available.

Result - Lose* indicates that the result was not available but that the progress of the hearing indicated that the result must be that the appellant lost her or his appeal.

Appendix 5
Interview schedules

A Chairmen/Presenting Officers/ Representatives

Background information
How long have you been an SSAT chairman/presenting officer/representative?
Did you chair/present/represent at Invalidity Benefit Tribunals?
How many Incapacity Benefit tribunals have you chaired/presented/represented?

Extra questions to representatives
At what stage do people usually approach you for advice?
- wanting help with filling in the all work test form
- wanting advice before the BAMS examination
- when they want to appeal
- after they have put an appeal in - and have a date for a hearing

The all work test
Is it a good way of assessing whether people are able to work or not?
What is good about it?
What is bad about it?
Do people with particular medical conditions have particular problems?
What about mental health problems?
How would you change it?

Information
What do you think about the papers that are provided for the tribunal?
Do they provide enough information about the case?
What further information would be helpful?

The all work test questionnaire
What do you think about the questionnaire?
How easy is it to fill in?
What problems do claimants have with filling in the form?
Do people with particular disabilities have particular difficulties?
What about mental health problems?
Did you think it is a good way of measuring whether people are able to work or not?

Bams examinations
What do you think about the information you receive from the BAMS examination?
What is good about the BAMS examination?
What is bad about it?
Would you make any changes to the way it was done?

Information from the appellant's GP

What do you think about the Med 4?

Tribunals
How do tribunals differ from Invalidity Benefit tribunals?

Chairmen

Questions to chairmen
What do you think the role of the chairman is?
How do you approach a tribunal?
(eg do you go for minimum points or do you see what is the most people can get? Do you start from scratch or start from the point of agreement?)
Do you ever find that an appellant is clearly not able to work but doesn't seem to fit the points system?
What would you do if that was the case?

Questions to presenting officers/representatives
Do you find that chairmen differ in the way they approach Incapacity Benefit appeals?
In what ways?
Do you think that one way is better than another?

Medical assessor
What difference does the medical assessor make?
Do you think that the medical assessor should be a full decision-making member of the tribunal, or is it better that she or he is not involved in the decision?

Presenting officer
Questions to chairmen/representatives
What is the role of presenting officers
Do they appear to be defending the adjudication officer's decision?
Do you find that they ever change their minds during the tribunal?

Questions to presenting officers
How do you see your role in a tribunal?
Do you see yourself as defending the adjudication officer's decision?
Is the adjudication officer's decision always a strong one?
If you felt that the adjudication officer's case was not very strong, what would you do?
If new evidence appears at the tribunal, would you change your view of the case - would you ever advocate that the appeal should be upheld?

Appellants
What happens when an appellant does not turn up for a tribunal?
What do you think about it when someone does not turn up?
Is there anything the Benefits Agency or the Independent Tribunal Service could do to encourage appellants to turn up?

Representatives
What difference does a representative make at a tribunal?
- to the appellant
- to the presenting officer
- to the chairman
How do claimants find out about representatives?
Do you think it is better if an appellant has a representative?
Should the Benefits Agency or the tribunal service do anything to encourage representation?

Extra questions to representatives
How do you publicise the fact that you can provide representatives?
When you represent someone at a tribunal, what is that you do that makes a difference? (compared with someone not having a representative)

Tribunals generally
Do tribunals provide a fair hearing?
What is good about tribunals?
What is bad about tribunals?
What would you change if you had the opportunity to make them different?

Appeal results
Do you know what the pattern of results is with Incapacity Benefit - how many appeals are upheld compared with those that are turned down?
How does that compare with Invalidity Benefit?
Do you think that the results of appeals affect:
- the way that adjudication officers make decisions?
- the procedures for assessing Incapacity Benefit?
If it appeared that a lot of people were winning their appeals, should that affect
- the way that adjudication officers make decisions?
- the procedures for assessing Incapacity Benefit?

What could be changed?
How could the procedures for assessing Incapacity Benefit be improved?
In the light of your experience the first year or so of Incapacity Benefit, is there anything about it that you would change?
Any other comments?

B Appellants

Background information
How long have you been claiming Invalidity Benefit/Incapacity Benefit? When did you start claiming?
When was your benefit reviewed - when did they send you the form to fill in?
When was the medical?
Have you ever been called in for a medical for your Invalidity Benefit before?
What happened that time?
What has happened to your benefit since the tribunal hearing?

The questionnaire
What did you think about the claim form?
Did you find it easy to fill in?
How easy did you find it to describe your particular disabilities/problems?
Do you find you have good days and bad days - how easy it was it to describe these on the form?
Was there anything you would like to have put on the form that you didn't put on it?
Why not?
Did you get any help with filling it in?
Who from - what help did they give you?
Did you think it was a good way of measuring whether you were able to work or not?

GP
Was your GP helpful in any way?
Do you think your GP's opinion should have more or less weight?

The BAMS examination
Can you remember what happened at the BAMS medical?
How long did it last?
What sort of things did the doctor ask you about?
Did the doctor ask you about anything that you hadn't mentioned on the form?
Did you think it was a good way of measuring whether you were able to work or not?

The tribunal
What did you think about the papers they sent you before the tribunal hearing?
Was the tribunal what you expected?
What was good about it?
What was bad about it?
Did you get a chance to say everything you wanted to say?

The medical assessor
What did you think about the doctor who was at the tribunal? What difference did she or he make to your case?

The presenting officer
What did you think about the person from the Benefits Agency - what difference did she or he make?

Representative

Either
You didn't have anyone with you at the tribunal - what difference do you think it would have made if you had taken someone along with you - for example from the CAB or an advice agency?

or
When did you get a representative?
How did you find out about getting a representative?
What difference do you think it made for you to have a representative with you?
What did the representative do?
How do you think you would have managed if you hadn't had a representative?

The decision
Did you understand the decision the tribunal made?
Do you think it was the right decision?

Appeal success rate
A lot of people seem to winning their appeals - what does that tell you about how Incapacity Benefit is working out?

Incapacity benefit generally
What do you think about the way they assess people for Incapacity Benefit now?
If you could decide how it was done, what changes would you make?

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